II. OFFICIAL POLICY

A. Basic Definitions

Department Regulation Section 360-5.2

When used in this manual, unless otherwise stated, the terms below shall be defined as follows:

1. **Disability** is the inability of an individual to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

2. **Blindness** is the total lack of vision or residual vision being no better than 20/200 or less in the better eye with a corrective lens or restriction of the visual fields or other factors which affect the usefulness of vision as prescribed in the appropriate medical criteria published in this manual. (For additional information see Section K.)

3. **Medically Determinable Physical or Mental Impairment** is an impairment resulting from anatomical, physiological, or psychological abnormalities which can be demonstrated by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings and not on the basis of the applicant/recipient's, (A/R's) statement of symptoms alone.

4. **Substantial Gainful Activity** is any work of a nature generally performed for remuneration or profit, which involves the performance of significant physical or mental duties. Work may be considered substantial even if performed part-time and even if less responsible than the individual's former work. It may be considered gainful even if it pays less than former work. (The application of this definition and of the amount of earnings that could result in a finding of substantial gainful activity is set forth in Section E.)

5. **Disability Review Team** is composed of a medical or psychological consultant and another person who is qualified to interpret and evaluate medical reports and other evidence relating to an individual's physical or mental impairments. As necessary, the other person also must be able to determine the individual's capability to perform substantial gainful activity. The Disability Review Team must review the medical report, which must

include a diagnosis, and medical and nonmedical evidence sufficient to determine whether the individual's condition meets the definition of disability.

Local districts may choose to have a psychologist as part of a review team; however, the psychologist may only evaluate mental impairment cases. It is not mandatory that a psychologist review cases involving mental impairments. For the purposes of the Medicaid disability review, a psychological consultant is a person who is licensed or certified for the independent general practice of psychology. "Independent general practice" of psychology means that the psychologist is entitled under State law to practice psychology without restriction or supervision.

6. **Disability Case Record** is compiled by the local district and should consist of the following:

   - A medical report including a diagnosis and other medical records.

   - Other non-medical evidence, such as a social history including the client's age, education, training, and past work experience in sufficient detail to enable the Disability Review Team to make a disability determination.

7. **Group I** is a classification that includes persons who show no possibility of engaging in any substantial gainful work activity because they have a physical and/or mental impairment(s) which is disabling and considered to be irreversible.

8. **Group II** is a classification that includes individuals who have impairments, which while disabling at the time of determination are expected to show an improvement in physical and/or mental status, which will enable them to become capable of substantial gainful activity. Some reasons for this improvement may be: the condition may be arrested; a remission may occur; therapeutic advances are occurring; and/or rehabilitation is deemed feasible.

B. **<u>Disability Eligibility</u>**

Department Regulation Section **360-5.6**

1. **Categorical Eligibility** - The following individuals shall be considered categorically disabled for purposes of Medicaid:

   a. Individuals who meet the statutory definition of disability.

b. Individuals who meet the statutory definition of blindness.

c. Deceased individuals - Deceased individuals are categorically eligible as disabled in the month of death. Therefore, disability reviews should be performed on Medicaid S/CC-related clients who die as well as in instances when an application is filed on behalf of a deceased individual. Disability status for months prior to the month of death depends upon whether the individual met the disability criteria setforth in this manual for prior time periods.

d. Grandfathered cases - Individuals who were determined disabled prior to January 1, 1974 under the Assistance to the Aged, Blind and Disabled (AABD) program for whom there was no interruption in their eligibility are eligible based on the medical criteria in effect at the time of the initial review.

Recipients determined disabled as a Group II prior to January 1, 1974 shall have their continuing eligibility determined on the basis of the medical criteria in effect at time of initial review. However, when there is a break in eligibility for any length of time, the individual loses his/her "grandfather" status and the case would have to be reviewed under the disability standards contained in this manual.

Group I recipients who were determined Group I under the AABD program and have no break in eligibility shall continue to be categorically related to disability. An exception would be if the recipient had significant medical improvement to the point where the recipient is no longer disabled.

2. **Derivative Eligibility**

a. The following individuals shall not require a determination of disability by the Disability Review Team:

(1) Individuals verified in receipt of or eligible for an Old Age, Survivors and Disability Insurance (OASDI) benefit under Title II of the Social Security Act as disabled or blind shall be considered disabled or blind for Medicaid purposes.

(2) Individuals verified as eligible for SSI as disabled or blind under Title XVI of the Social Security Act shall be

considered disabled or blind for Medicaid.

(3) Individuals verified in receipt of Railroad Retirement benefits as totally and permanently disabled.

These groups of individuals are considered disabled until the date the Social Security Administration will or would have reevaluated the individual's medical condition, (the medical diary date).

b. Disability status under the SSI and OASDI programs shall be verified as follows:

(1) Award letter (case file information should include A/R's name, amount of award, onset of disability and date of entitlement);

(2) Completion of Form 1610, "Public Agency Information Request" by the local Social Security District Office;

(3) Presentation of a current monthly benefit check for disability; or,

(4) Inquiry through the State Data Exchange (SDX).

c. Individuals in receipt of SSI are automatically eligible for Medicaid. A separate application for Medicaid is not required, nor is a disability review necessary. (For additional information see Section I.)

C. Local District Responsibilities

1. Identifying Disabled Persons

a. Responsibility for Detecting Disability

The initial responsibility for detecting disability rests primarily with the eligibility worker. Effort should be made to identify disability-relatedness at the time of initial eligibility determination or recertification for Medicaid. In addition, all workers in the local agency should be alert in their contacts with persons receiving S/CC categorically related financial assistance (single individuals and childless couples receiving Safety Net cash assistance) or S/CC-related Medicaid to recognize when the applicant/recipient (A/R) may be disabled. This is important in order to maintain cost neutrality under the

1115 waiver and also to benefit the A/R. Prompt identification of the condition, together with prompt initiation of disability certification, may be advantageous to the individual. Such advantages may include: identification and provision of medical or social services needed to improve the individual's condition, and provisions for more favorable budgeting disregards.

To identify all who qualify for Medicaid disability, eligibility workers should have a general knowledge of the health status of applicants and recipients. The best source for securing knowledge of an individual's health status is the A/R or, if the person is represented by another, his/her representative. By conveying a sense of interest, respectful listening and inquiring as to the individual's health, the worker will find that most persons will discuss their health problems, particularly if ill health is the precipitating reason for the application for Medicaid.

Readily apparent conditions which are disabling, such as loss of arm(s) or leg(s), extensive paralysis or crippling, evidence of mental retardation and the bizarre and inappropriate behavior a psychotic person may exhibit, may easily be identified through the worker's own observations or by speaking with family members or other representatives of the A/R. In addition, groups of persons such as those confined to nursing homes or their own homes because of chronic illness and who cannot make an application in person will be readily recognized as candidates for Medicaid disability.

b. Worker's Observations of the Applicant/Recipient's Symptoms Which May Indicate Disability

The worker's observations of the applicant/recipient are also important in detecting disability. Some of the more common indicators which a worker may observe or be informed about and may indicate the existence of a chronic health problem are as follows:

(1) **Physical Disability**

- restricted mobility/unable to walk without aid
- limited use/weakness in hands or fingers
- amputation/paralysis of limbs
- uncoordinated body movements/palsy
- difficulty in breathing/talking, or speech
- shortness of breath/asthma attacks
- difficulty in sitting, standing, lifting, bending,

kneeling, pushing, pulling
- chronic coughing/wheezing
- dizziness/drowsiness/blurred vision
- nausea/diarrhea/colitis
- poor hearing/deafness/inability to use hearing aid
- poor vision/blindness/inability to read print
- memory loss/blackouts/headaches
- low energy level/chronic tiredness/fainting spells

(2) **Mental Disability**

- severe anxiety/nervousness
- acting out/hallucinations/crying
- disorientation/confusion, non-responsiveness
- inappropriate responses/reactions
- unusual fears inhibitions, or mannerisms
- poor personal hygiene habits, unkempt appearance
- bizarre appearance, inappropriate dress
- unusual or inappropriate mood/depression
- agitated, disruptive or hostile behavior
- poor concentration or attention span
- poor memory for recent or remote events

(3) **Medical Factors/History**

- multiple/extended hospitalizations
- periodic confinement in mental institutions or facilities
- history of treatment in mental health clinic or private therapist
- high medication usage or drug expenditure
- use of, or dependency on, prosthesis or medical appliances such as walker, crutch, artificial limb, cane, body brace, hearing aid, special glasses, magnification device or pacemaker
- severe dietary restrictions/malnutrition
- severe or sudden weight loss/extreme obesity
- complaints of constant or periodic pain
- uncontrolled or semi-controlled epilepsy or seizures
- treatment for cancer/cancer treatment related conditions
- history of heart trouble/stroke/surgery
- recurrent chest pain

(4) **Vocational Factors**

- poor/inconsistent work history
- chronic unemployment, lack of work skills
- frequent job terminations
- loss/deterioration of work skills
- attendance in special education class
- previous participation in sheltered workshop/ rehabilitation facility
- age 55 or over

Indicators such as the above, especially when accompanied by information from the A/R of the existence of a health problem, indicate that the A/R should be reviewed for disability. A "Desk Aid" listing most of these factors may be found in Forms and Publications.

Children under 18 years of age may demonstrate behavior(s) and/or a level of functioning which is significantly below that which is appropriate for the child's chronological age. Such an observation may indicate that the child should be reviewed for disability.

2. **Informing the Applicant/Recipient**

The worker shall provide the A/R with the following information concerning the disability category for Medicaid.

a. The advantages of disability certification;

b. The procedures and the timeframes involved in the disability determination process;

c. The A/R's responsibility to provide and/or cooperate with the local agency in obtaining medical evidence which shows that the A/R is disabled. The local agency will provide assistance to the A/R in obtaining medical reports when the A/R has given the agency permission to request them from his/her doctors and other medical sources;

d. When requested by the local agency, the responsibility of the A/R to provide information about his/her age, education and training, work experience, past and current daily activities, efforts to work and any other evidence showing how the A/R's impairment(s) affects his/her ability to work;

e. The A/R's responsibility to take part in a consultative medical

examination or test which is needed by the Disability Review Team to determine if the A/R is disabled. If the A/R fails or refuses to take part in a consultative examination without good cause, s/he may be found to be not disabled;

f. The right of the A/R to receive written notification of the Disability Review Team's decision. Form DSS-4141 "Notice of Medical Assistance Disability Determination" is used for this purpose (See Exhibit 20). The local agency may either attach a copy of the DSS-639 "Disability Review Team Certificate" (See Exhibit 1) to this notice or transfer the information from Item 10 of the Certificate to the DSS-4141. For approved cases only, the following standardized language may be substituted for the rationale contained in Item 10: (*insert name)*, meets the definition of disability, 18 NYCRR 360-5.2(b), which states, in part, that "disability is the inability to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental impairment...."

g. The right of the A/R to receive a written statement as to the reasons the determination has not been rendered within 90 days of the date of application/recertification. (See Exhibit 9.);

h. The A/R's right to a conference with the local district; and

i. The A/R's right to a fair hearing on the action which may ensue as a result of the A/R's failure to cooperate, or on the delay in prompt action in making the determination; or on any action or non action which results from the determination.

3. **Securing Medical Documentation**

a. The local agency, in cooperation with the A/R, shall attempt to obtain all available medical information from the A/R's treating sources, since these records will help establish a longitudinal medical history. This information shall cover the timeframe for which a disability determination is being considered and in many cases should include the 12 months prior to the date of application. These medical records may include:

(1) Medical history;

(2) Clinical findings (such as the results of physical and/or mental status examinations);

(3) Laboratory findings and diagnostic procedure results, such as blood pressure, X-ray reports, electrocardiogram results, pathology reports, pulmonary function test results and blood and urine analysis reports;

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis;

(6) Medical assessment of functional capacity (except in statutory blindness cases) including:

(a) Limitations in ability to do work-related activities such as sitting, standing, moving about, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(b) In cases of mental impairment, limitations in the ability to reason, remember, understand and carry out instructions; to maintain attention and concentration; to sustain an ordinary routine; to respond appropriately to criticism from supervisors; and to get along with co-workers.

b. Medical evidence forms the foundation for determination of disability. The existence of a disabling condition must be based on a substantiated medical report(s) from acceptable medical sources. Acceptable medical sources are:

(1) Licensed physicians;

(2) Licensed osteopaths;

(3) Psychologists, including school psychologists, who are licensed or certified for the independent general practice of psychology;

(4) Licensed optometrists for the measurement of visual acuity and visual fields;

(5) Licensed podiatrists for purposes of establishing impairments of the foot and ankle;

(6) State certified speech-language pathologists for purposes of establishing speech or language impairments; and

(7) Persons authorized by a hospital, clinic, or health care facility to provide a copy or summary of the individual's medical records.

c. Information from other sources may also help to show how the individual's impairment(s) affects his/her ability to perform work-related activities. Other sources include:

(1) Other practitioners such as physician's assistants, chiropractors, audiologists, physical and occupational therapists, nurse practitioners, and naturopaths;

(2) Educational personnel such as teachers, guidance counselors, early intervention team members, day care workers;

(3) Public and private social welfare agencies.

d. The medical evidence, including the clinical and laboratory findings, shall be complete and detailed enough to allow a determination as to whether or not the individual is disabled. It must allow a determination of:

(1) The nature and severity of the impairment(s) and the extent of limitation imposed by the impairment(s) for the time period in question;

(2) The probable duration of the impairment(s); and

(3) Residual functional capacity to do work-related physical and mental activities.

e. If the individual's medical sources are unable to provide sufficient medical evidence regarding the A/R to enable the Disability Review Team to make a determination, a consultative examination may be required.

4. **Completion of Forms**

At a minimum, each case record submitted for a disability determination must contain a medical report which contains a diagnosis and sufficient medical and non-medical evidence to make a determination. While the forms that follow are not mandated, the information they solicit is generally necessary in order to make a determination of disability. (See Policy 2 for definition of case record.)

a. Form DSS-1151 "Disability Interview" and Form DSS-1151.1 "Disability Interview Continuation Sheet" (See Exhibit 4.)

The DSS-1151 should be completed as thoroughly as possible. The DSS-1151 is usually completed by the agency worker who interviews the client but may be filled out by the client or his/her representative.

Part 1- Information About Impairments - should contain the A/R's description of his/her impairments, any symptoms he/she experiences such as shortness of breath, pain, anxiety, and how it affects the A/R's ability to perform work activities.

Part 2- Information About Medical Records - should be thoroughly completed to help ensure that all recent medical sources and records have been identified.

Part 3- Information About Your Activities - should contain specific information on what activities the A/R performs on a daily basis and what activities if any, the physician has suggested limiting.

Part 4- Information About Education and Literacy - all areas should be completed for consideration by the Disability Review Team in the vocational evaluation.

Part 5- Information About the Work You Did in the Past 15 Years - information about specific duties and activities in previous jobs must be thoroughly completed, so that the Disability Review Team can properly perform the vocational assessment in the sequential evaluation process. The kind and amount of physical activity should be circled for each job.

Part 6- Interviewers Observations - should include the worker's observations of the A/R's symptoms and limitations, e.g., obvious hearing, visual or speech limitations, difficulties in walking, sitting or standing, signs of confusion, disorientation, and inappropriate behavior. It may include any other information that may be relevant for the Disability Review Team.
The DSS-1151.1 is a continuation sheet and should be used to report additional medical and/or employment information concerning the A/R.

b. Form DSS-486 and Form DSS-486T "Medical Report for Determination of Disability" (See Exhibit 3 and Exhibit 21).

Either one of these forms can be used to secure medical information about the A/R. The local agency may either give one of these forms to the A/R to take to

his/her physician or send the form(s) directly to the physician for completion.

5. **Referral to Disability Review Team**

The medical documentation and completed forms are submitted to the Disability Review Team for a determination of disability in accordance with procedures detailed in this manual. The Disability Review Team must complete Form DSS-639 "Disability Review Team Certificate" for each case that is reviewed for disability. A copy of this form and directions for completion are found in the Forms & Publications Section.

6. **Pending of Disability Cases**
Department Regulation Section 360-2.4, 360-5.7

Generally, eligibility must be determined within 45 days of the date of application; however, when determining categorical relatedness to disability the following applies. Disability status must be determined within 90 days of application. This time standard applies except in unusual circumstances such as where the agency cannot reach a decision because of failure or delay on the part of the A/R or an examining physician, or for reasons not within the control of the agency. In such circumstances, the case record must show the cause of the delay. This pending period for acting on applications or redeterminations of eligibility shall not be used as a waiting period before granting Medicaid to eligible persons. If a case is pended more than 90 days, this delay shall not be a basis for denying Medicaid or for terminating assistance.

If a case is pended, the local agency should take one of the following courses of action:

a. If the case is eligible under another category of assistance, the case should be authorized. If the case is subsequently determined eligible as disabled, an adjustment for funding under the SSI-related category of assistance can be made for medical bills paid under the S/CC category.

b. Cases which are not eligible under any other category should be pended awaiting a decision from the Disability Review Team. Medicaid cannot be provided for these individuals until they are determined disabled.

c. If the A/R has not been contacted during the 90 day period, the A/R must be sent a statement at this time informing him/her that a decision has not been made as yet. (See Exhibit 9.)

7. **Submitting Cases for Continuing Disability Review (CDR)**

Cases determined Group II, by the Disability Review Team, have an expiration date and must be reviewed periodically. Approximately one to two months prior to the expiration date, the local agency should prepare the case for submission to the Disability Review Team for a continuing disability review. The case record should contain current social and updated medical information as well as the complete case record from prior case review(s), including the disability certificate (DSS-639).

Agency personnel should be sure that all the necessary information for a continuing disability review is secured and submitted to the Disability Review Team before the Group II certificate expires. The case must be kept open pending the Disability Review Team's medical re-evaluation if the A/R is still otherwise eligible in the SSI-related category.

The CDR evaluation process is described in Section G.

8. **Responding to Disability Review Team Decisions**

a. If the decision is either "Approved" or "Disapproved" the case shall be processed and the A/R shall be notified according to Policy 7.

b. If the decision is "No Action" the local agency in conjunction with the A/R shall attempt to obtain the information requested by the Disability Review Team as expeditiously as possible and resubmit the case to the Disability Review Team.

c. If the individual's medical sources are unable to provide sufficient medical evidence to enable the Disability Review Team to make a determination, a consultative examination may be required according to procedures set forth in Policy 21.

D. Evaluation of Disability

1. **General**

The Disability Review Team is responsible for a determination as to whether or not an individual is disabled. The Disability Review Team must consider all of the pertinent facts of the case. In those cases where a determination of disability cannot be made based on medical evidence alone, the following vocational factors must be considered in conjunction with the medical evidence:

a. The individual's residual functional capacity as defined on Policy 24;

b. The individual's age, education, training and work experience in the past 15 years; and

c. The kinds of substantial gainful activity (work) which exist in significant numbers in the national economy for someone with this individual's limitations. (See Policy 33.)

2. **Sequential Evaluation Process for Adults**

The Disability Review Team must use the Sequential Evaluation Process to determine whether the A/R is or is not disabled. This process consists of steps which must be followed in sequence. However, if at any step of this process, a determination can be made that an A/R is disabled, evaluation under a subsequent step is unnecessary. (See Sequential Evaluation Flow Chart on Policy 17.) Please note that this is the Sequential Evaluation Process for Adults. The Sequential Evaluation Process for children under 18 years of age is discussed in Section M.

a. Is the A/R working and is the work considered substantial gainful activity as defined in Section E? If so, the individual is determined not disabled. (This decision is made by the local district.)

b. Does the A/R have a severe medically determinable physical or mental impairment or combination of impairments which significantly limit his/her ability to do basic work activities? A severe impairment is an impairment or combination of impairments that significantly limits physical or mental ability to do basic work activities. Examples of basic work activities are walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions, using judgement, responding appropriately to supervision, co-workers and usual work situations, and dealing with changes in a routine work setting.
If the individual does not have a severe medically determinable impairment, the individual is determined not disabled.

c. Does the A/R have a physical or mental impairment which has lasted or is expected to last 12 months or more, or result in death? If the impairment does not meet this 12-month duration requirement, the individual is determined not disabled.

d. Does the A/R have any impairment(s) which meets or equals a listing in Appendix I? When an individual's impairment(s) meets the duration requirement and either meets a listing in Appendix I or is determined to be medically the

equivalent of a listed impairment, a finding of disability shall be made without the need to consider the vocational factors. ("Meeting" or "equaling" a listing is explained on Policy 18-19.)

e. Does the A/R have an impairment(s) which prevents the performance of past relevant work? When a disability determination cannot be made based on current work activity or on medical considerations alone, an evaluation shall be made of the individual's residual functional capacity (RFC) and the physical and mental demands of his/her past relevant work. The Dictionary of Occupational Titles (DOT), which includes information about jobs that exist in the national economy, is used to determine the physical, mental and skill requirements of the individual's past work. If the impairment does not prevent the A/R from meeting the physical and/or mental demands of past relevant work, the A/R shall be determined not disabled. (Use of the DOT begins on Policy 32.)

f. When an A/R with a marginal education (6th grade or less) and long work experience (e.g., 35-40 years or more), which was limited to the performance of arduous, unskilled, physical labor, is no longer able to perform such work because of an impairment, such individual shall be determined disabled.

g. Does the A/R's impairment(s) prevent him/her from making an adjustment to any other work? If an individual is found unable to perform past relevant work, the factors of age, education and work experience must then be considered in addition to the functional limitations imposed by the individual's physical or mental impairment(s) to determine whether there is any work in the national economy that the individual has the RFC to perform. If the individual's functional capacity and vocational ability make it possible for the individual to make an adjustment to other work which exists in the national economy, the A/R shall be determined not disabled. (The Medical Vocational evaluation process is described in Section D 4 and Appendix 3.)

h. Different rules are used to meet one of the three special medical-vocational profiles described below. If the A/R meets one of these profiles, it will be determined that s/he cannot make an adjustment to other work and is, therefore, determined disabled.

Medical-vocational profiles showing an inability to make an adjustment to other work.

(a) If an individual has done only arduous unskilled physical labor.

If the A/R has no more than a marginal education and work experience of 35 years or more during which s/he did only arduous unskilled physical labor,

and s/he is not working and is no longer able to do this kind of work because of a severe impairment(s), the individual is considered unable to do lighter work and is, therefore, disabled.

Example: Mr. X is a 58 year-old miner's helper with a fourth grade education who has a lifelong history of unskilled arduous physical labor. Mr. X says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a "severe" combination of impairments that prevent Mr. X from performing his past relevant work. Under these circumstances, Mr. X will be found disabled.

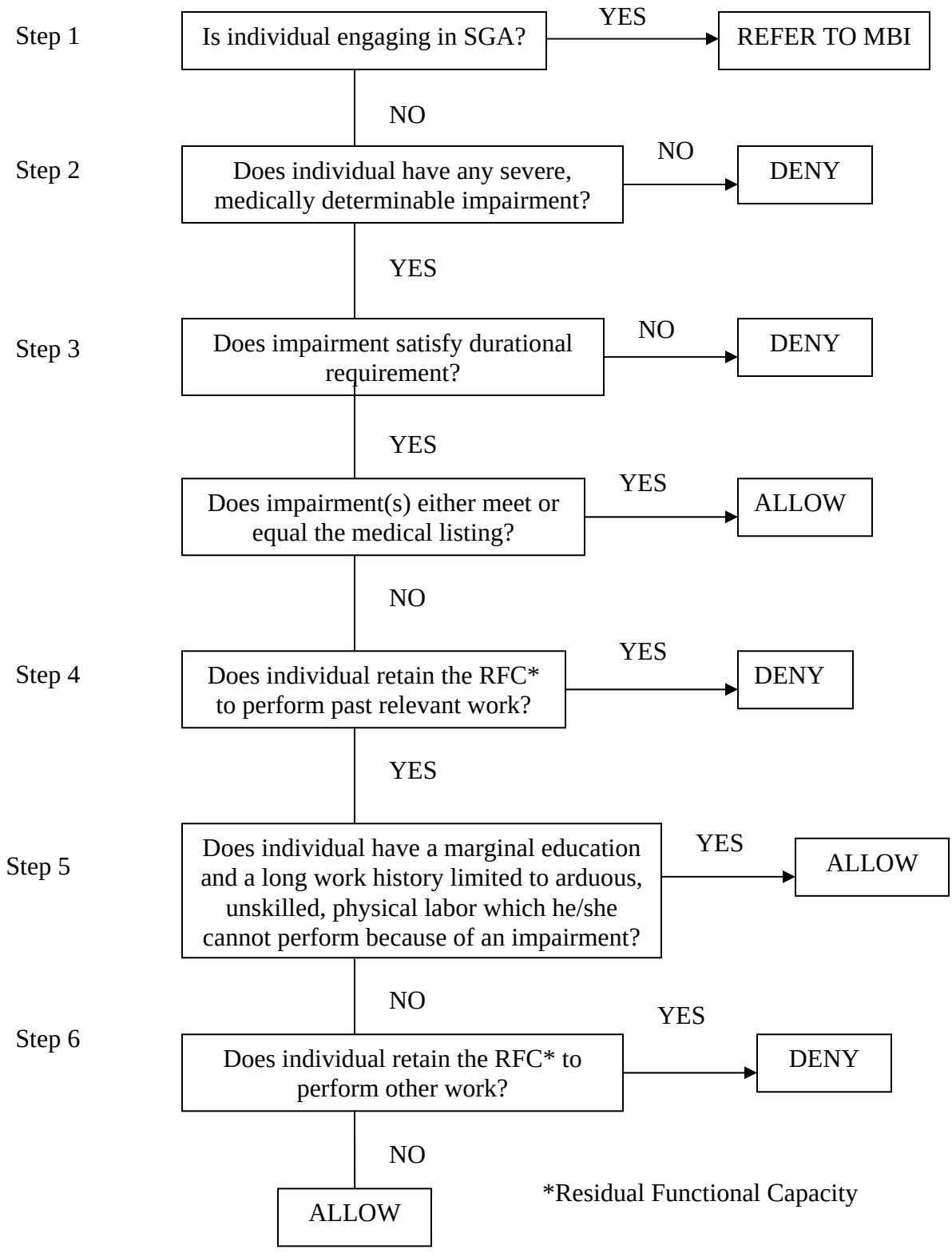
(b) If the individual is at least 55 years old, has no more than a limited education, and has no past relevant work experience.

If the A/R has a severe, medically determinable impairment(s), is of advanced age (age 55 or older), has a limited education or less, and has no past relevant work experience, s/he will be found disabled. If the evidence shows that the individual meets this profile, there is no need to assess his/her residual functional capacity or consider the rules in Appendix II (Medical Vocational Guidelines).

(c) If the individual is closely approaching retirement age (age 60 or older), has a lifetime commitment to unskilled work, or skilled or semiskilled work but with no transferable skills.

If the individual is closely approaching retirement age (age 60 or older), has no more than a limited education, has a lifetime commitment (30 years or more) to a field of work that is unskilled, or is skilled or semi-skilled but with no transferable skills, is not working at SGA level and can no longer perform this past work because of a severe impairment, s/he will be found disabled.

To satisfy the requirement for this profile, the 30 years of lifetime commitment work does not have to be at one job or for one employer but rather work in one field of a very similar nature. If the person has a history of working 30 years or more in one field of work, the use of this profile will not be precluded by the fact that the person also has work experience in other fields, so long as that work experience in other fields is not past relevant work which the person is still able to perform.


Step 1
Is individual engaging in SGA?
YES
REFER TO MBI
NO
Step 2
Does individual have any severe, medically determinable impairment?
NO
DENY
YES
Step 3
Does impairment satisfy durational requirement?
NO
DENY
YES
Does impairment(s) either meet or equal the medical listing?
YES
ALLOW
NO
Step 4
Does individual retain the RFC* to perform past relevant work?
YES
DENY
YES
Step 5
Does individual have a marginal education and a long work history limited to arduous, unskilled, physical labor which he/she cannot perform because of an impairment?
YES
ALLOW
NO
Step 6
Does individual retain the RFC* to perform other work?
YES
DENY
NO
ALLOW
*Residual Functional Capacity

3. **Medical Considerations**

a. Medically Determinable Impairment - To qualify as disabled, an individual is required to have a medically determinable impairment. This is a physical or mental impairment which results from anatomical, physiological or psychological abnormalities that are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consists of signs, symptoms, and laboratory findings as defined below.

(1) **Signs** - Anatomical, physiological or, psychological abnormalities which can be observed apart from the A/R's statements (symptoms). Signs must be demonstrated by medically acceptable clinical diagnostic techniques. Psychiatric signs must also be shown by observable facts which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality.

(2) **Symptoms** - An individual's own perception of his/her impairment(s). The individual's statements alone are not sufficient to establish that there is a physical or mental impairment.

(3) **Laboratory findings** - Results of such diagnostic techniques as chemical tests, X-rays, electrocardiograms, electroencephalograms, psychological tests and medical examinations.

b. Listing of Impairments in Appendix I - The Listing of Impairments describes, for each of the major body systems, impairments which may prevent a person from doing substantial gainful activity. The listing gives specific medical findings which are required to establish or confirm the existence of and extent of an impairment. The medical findings consist of signs, symptoms and laboratory findings. To "Meet a Listing" the A/R must have the diagnosis of a listed impairment and the specific medical findings provided in the listing for that impairment. The Listing of Impairments consists of two parts - Part A which applies to adults age 18 years and over and Part B which applies to individuals under the age of 18. Part B shall be used initially for individuals under age 18 and if the medical criteria in Part B does not apply, then the medical criteria in Part A is used to evaluate the impairment(s).

c. Multiple Impairments - If an individual has multiple impairments, none of which individually meets or equals a listed impairment, the combined effect of the impairments must be evaluated to determine the impact on the individual's physical or mental capacity to engage in substantial gainful activity. The combined impact of all impairments must be considered throughout the disability

determination process.

Two or more unrelated impairments shall not be combined to meet the 12-month duration test in an initial determination. If an individual has an impairment(s) and then develops another unrelated impairment(s), and the two impairments in combination would last 12 months, but neither one by itself is expected to last for 12 months, the individual shall be found not disabled.

When an individual has two or more concurrent impairments which, when considered in combination constitute a disability according to criteria set forth in this Manual, a determination shall be made as to whether the combined effect can be expected to last for 12 months. If one or more of the impairments improves or is expected to improve within 12 months so that the combined effect of the remaining impairment(s) no longer meets the criteria for disability, the individual shall be found not to meet the 12-month duration test.

d. Medical Equivalence - If an individual does not qualify because the impairment does not exactly fulfill one of the listing specifications, the individual may be determined to equal the listings in one of the following ways:

If the individual has a listed impairment but does not exhibit one or more of the medical findings specified in the listing, or exhibits all of the medical findings but one or more of the findings is not as severe as specified in the listing, the individual may be found to equal the listing if there are other medical findings related to the impairment that are at least of equal medical significance.

If the individual has an unlisted impairment or a combination of impairments no one of which meets or equals a listing, the medical findings are compared to medical findings for a closely related impairment. If the medical findings are at least of equal medical significance to those of a closely analogous listed impairment, the individual is found to equal the listing.

e. Evaluating Medical Opinions

(1) Every reasonable effort must be made to obtain the medical evidence necessary to evaluate an A/R's disability from his or her medical sources (that is, the A/R's own physicians or psychologists, hospitals or clinics where s/he has been treated or evaluated, etc.) before obtaining medical evidence from another source on a consultative basis. Controlling weight will be given to the medical opinion of any treating source on the issues of the nature and the severity of the impairment, when the opinion is well supported by medically acceptable clinical and laboratory techniques and

is not inconsistent with other substantial evidence in the record.

When a treating source's medical opinion is not given controlling weight, good reasons for such a decision are required and should be documented. When controlling weight cannot be given to a treating source's opinion, all of the following factors will be considered in determining how much weight to give to the opinion:

(a) The medical opinion of an examining source will generally be given more weight than that of a non-examining source.

(b) Treating sources are the most likely to be the medical professionals most able to provide a detailed, longitudinal picture of a medical impairment, as well as a unique perspective which the medical evidence alone cannot provide. Therefore, the medical opinions of treating sources are given controlling weight, if their opinions on the nature and severity of the A/R's impairment are well supported by medically acceptable clinical and laboratory diagnostic techniques, and are not inconsistent with other substantial evidence in the case record. The weight given to a treating source will be determined by considering the length, frequency, nature, and extent of the relationship between the treating source and the A/R.

(c) The more relevant the supporting evidence of an opinion, particularly medical signs and laboratory findings, and the better an explanation a medical source provides, the more weight that opinion will be given. Because nonexamining sources have no examining or treating relationship with the A/R, the weight given to their opinions will depend on the degree to which they supply supporting explanations for their opinions.

(d) The more consistent a medical opinion is with the record as a whole, the more weight that opinion will be given.

(e) More weight will be given to the opinion of a medical specialist about medical issues related to his/her area of specialty than to the opinion of a source who is not a specialist in that area.

(f) Other factors may affect the weight given to a medical opinion. For example, information that a particular physician or psychologist has been submitting similar medical reports for

different individuals could potentially affect the weight that such reports would be given.

The manner in which a decision should be made, once all of the medical evidence is reviewed, is discussed on Policy 24.

f. Consultative Examination
Department Regulation 360-5.5

(1) The local agency must purchase an examination for an A/R who does not have a current treating source, or whose treating source is unwilling or unable to provide required medical evidence. If the A/R's medical source(s) cannot or will not provide sufficient medical evidence to allow the reviewer to make a disability determination, the A/R may be required to have one or more physical or mental examinations or tests. The type of medical provider should be appropriate for the type of examination or test required. Some reasons why the Disability Review Team may need more medical evidence are:

(a) The additional evidence needed is not in the records of the A/R's medical sources;

(b) The evidence that may have been available from the A/R's treating or other medical sources cannot be obtained for reasons beyond the A/R's or district's control, such as lack of cooperation on the part of a medical source;

(c) Necessary technical or specialized medical evidence is not available from the A/R's medical sources;

(d) A conflict, inconsistency, ambiguity, or insufficiency in the evidence must be resolved, and such conflict(s) cannot be resolved by recontacting the A/R's medical source(s); and

(e) There is an indication of a change in the A/R's condition that is likely to affect the A/R's ability to work, but the current severity of the A/R's impairment is not established.

When the A/R's treating physician is qualified, equipped, and willing to perform the additional examinations or tests, and generally provides complete and timely reports, the A/R's treating physician or psychologist will be the preferred source to perform

a purchased examination. If the A/R's treating source(s) requests payment to complete the "Medical Report for Determination of Disability" (DSS-486 or DSS-486T) or to provide available medical records, the local agency must pay for the information, if appropriate.

If the A/R objects to being examined by a designated physician or psychologist, and there is a good reason for the objection (e.g., language barrier, travel restrictions, a previous examination for disability which was unfavorable), the exam should be scheduled with another physician/psychologist, whenever practical.

Medical examinations, including psychiatric and psychological examinations, X-rays, and laboratory tests (such as pulmonary function tests, electrocardiograms, blood tests, etc.) may be purchased from a licensed physician, psychologist, hospital or clinic. However, tests which entail significant risk to the A/R, such as myelograms, arteriograms, or cardiac catheterizations, may not be required for the evaluation of disability.

As with any item of evidence in the case record, consultative examination reports will be reviewed for accuracy and completeness, internal consistency, and consistency with the rest of the case record.

(2) **Cost of consultative examinations**

(a) The cost of the completion of medical forms, diagnostic tests, examination(s), and consultation(s) necessary to document disability shall be paid by the local agency.

However, the local agency will not pay for any medical examination and/or test arranged by the A/R or his/her representative without the local agency's request. In order for a local agency to pay for an examination or completion of Form DSS-486, Form 901 ("Authorization for Medical Examination and Payment Request") should be completed and signed by agency personnel. (See Exhibit 11.)

(b) Such costs shall be subject to reimbursement as an administrative expense whether or not the A/R is subsequently determined disabled. Federal financial participation shall be claimed for such expenditure even if the individual is subsequently determined not disabled.

(3) **Responsibility to disclose consultative examination information**

(a) Local districts shall ask the A/R if he/she wants to have the consultative examination information sent to his/her primary treating source. If so, a consent form for release of this information shall be signed prior to the purchase of the consultative examination. (See Exhibit 19.)

(b) Local districts shall send consultative examination information to an A/R's primary treating source if the A/R has signed the consent form for release of this information. These referrals are particularly important when the Disability Review Team determines that medical evidence obtained during a consultative examination indicates a potential life-threatening situation, such as a previously undiagnosed condition that may require immediate treatment. Examples of such conditions are: suspicion of a previously undetected carcinoma, serious new electrocardiogram abnormalities or a new mass on a chest x-ray.

(c) If a potential life-threatening situation is identified and the A/R has not signed a consent form and/or does not have a treating source, the local district shall advise the A/R in writing of the life-threatening situation and the need to see a physician for an examination and/or additional testing. The A/R should also be informed that the cost of the subsequent examination(s) and/or test(s) will not be paid by Medicaid unless the A/R is eligible for Medicaid and the medical service is reimbursable by Medicaid. In addition, if needed, the local districts shall assist an A/R in identifying a potential treating source.

(4) **Failure or refusal to take part in an examination or test -** The individual's failure or refusal to take part in a consultative examination(s) or test(s) without good cause shall be regarded as a failure or refusal by the individual to cooperate in the disability determination process.

g. Evaluation of Medical Evidence

After all of the medical evidence has been reviewed, a decision is made as to what the evidence shows. If the evidence is consistent and is sufficient to make a determination, a determination should be made. If the evidence is consistent, but is insufficient to make a determination, efforts will be made to obtain additional

information.

If the evidence is inconsistent, the evidence will be weighed as a whole to decide whether a determination may be made based on the available evidence. Where there are inconsistencies that cannot be resolved, or when attempts to obtain additional information for cases which are incomplete are unsuccessful, a determination will be made based upon the available evidence.

4. **Vocational Considerations**

a. Residual Functional Capacity (RFC) - The individual's impairment(s) and any related symptoms such as pain may cause physical and mental limitations that affect what s/he can do in a work setting. Residual functional capacity is the most an individual can still do despite his/her limitations. An individual's residual functional capacity is assessed based on all the relevant evidence in the case record. If the individual has more than one impairment, the reviewer is to consider all of the individual's medically determinable impairments including those that are not "severe" when assessing the individual's residual functional capacity. An RFC assessment includes an evaluation of the individual's physical capabilities as well as work-related limitations imposed by any non-exertional impairment(s) (i.e., mental, manipulative, seeing, hearing, speaking, etc.). This assessment is not a decision as to whether an individual is disabled but is used to determine the particular types of work an individual may be able to do despite his/her impairment(s). Once the individual's RFC is established, it is used to determine his/her maximum sustained work capacity, which is the highest functional level a person can perform on a regular work basis. In order to limit an individual to a particular functional level (i.e., sedentary, light, etc.), an individual must be limited to at least that level for the timeframe under consideration for disability.

(1) **Physical Impairment** - If the individual has a physical impairment, an assessment of the individual's ability to perform certain work-related activities, such as sitting, walking, standing, lifting, carrying, reaching, handling, pushing, pulling, stooping, and crouching shall be made. In order to say that an individual can do a certain job, s/he must have physical capacities equal to the physical demands of that job. (See Appendix 3 and Exhibit 7.)

To determine the physical exertion requirements of work in the national economy, the following classifications shall be used. These terms have the same meaning as they have in the Selected Characteristics of Occupations in the Dictionary of Occupational Titles.

(a) **Sedentary work** involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like files, ledgers, and small tools. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) **Light work** involves lifting 20 pounds maximum with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must be capable of performing substantially all of the foregoing activities. The functional capacity to perform light work generally includes the functional capacity to perform sedentary work.

(c) **Medium work** involves lifting 50 pounds maximum with frequent lifting or carrying of objects weighing up to 25 pounds. The functional capacity to perform medium work includes the functional capacity to perform sedentary work and light work as well.

(d) **Heavy work** involves lifting 100 pounds maximum with frequent lifting or carrying of objects weighing up to 50 pounds. The functional capacity to perform heavy work includes the functional capacity to perform work at all of the lesser functional levels.

NOTE: If an individual is unable to perform a full range of sedentary work, which includes lifting ten pounds; standing or walking two hours a day or sitting six hours a day; the individual is considered to be limited to a "less than sedentary" exertional level and is therefore disabled.

(2) **Non-exertional limitations** - Any medically determinable impairment(s) resulting in non-exertional limitations (such as mental, sensory, or skin impairments) must also be considered in terms of the limitations resulting from the impairment. When an individual has a non-exertional impairment in addition to an exertional impairment(s), the residual functional capacity must be assessed in terms of the degree of any additional narrowing of the individual's work-related capabilities.

(3) **Mental Impairment** - The assessment of an impairment because of a mental disorder(s) includes consideration of such factors as the capacity to understand, concentrate and persist at tasks, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and customary work pressures in a routine work setting. (See Exhibit 6 for a more complete explanation of the mental impairment residual functional capacity assessment process.)

(4) **Relationship of residual functional capacity to ability to do work -** When the individual's residual functional capacity is sufficient to enable the individual to do his or her past relevant work, a determination is made that the individual is not disabled.

When the individual's residual functional capacity is not sufficient to enable the individual to do his or her past relevant work, it must be determined what work, if any, the individual can do. The individual's residual functional capacity, age, education, and work experience are taken into consideration in making this determination. Consideration must also be given to whether work that the individual can do exists in significant numbers in the national economy as defined on Policy 33.

NOTE: If an individual is limited to a "less than sedentary" exertional level, the individual is determined disabled. According to the Dictionary of Occupational Titles, there are no jobs in the national economy that are categorized as "less than sedentary" and therefore, there are no jobs that this individual is able to perform.

b. Age as a vocational factor

General. The term "age" refers to chronological age. When deciding whether an individual is disabled, consideration will be given to the individual's chronological age in combination with his/her residual functional capacity, education, and work experience. Consideration will not be given to the individual's ability to adjust to other work on the basis of age alone. In determining the extent to which age affects a person's ability to adjust to other work, advancing age is considered to be an increasingly limiting factor in the person's ability to make such an adjustment. If the individual is unemployed but still has the ability to adjust to other work, he/she may be found not disabled.

How age categories are applied. When making a finding about the individual's ability to do other work, the age categories in paragraphs (1) through (3) of this

section should be used. Each of the age categories that apply to the individual for the period in which disability is being determined will be used. The age categories will not be applied mechanically in a borderline situation. If the individual is within a few days to a few months of reaching an older age category, and using the older age category would result in a determination or decision that the individual is disabled, consider whether to use the older age category after evaluating the overall impact of all the factors in the case.

(1) **Younger individual** - In the case of a younger individual (under age 50), age is generally not considered to seriously affect the individual's ability to adjust to other work. However, in some circumstances, persons age 45 - 49 may be considered more limited in their ability to adjust to other work than persons who have not attained age 45. See Rule 201.17 in Appendix 2.

(2) **Individual Closely Approaching Advanced Age** - For the individual who is closely approaching advanced age (age 50-54), the factor of age, in combination with a severe impairment(s) and limited work experience, may seriously affect the individuals ability to adjust to other work.

(3) **Individual of Advanced Age** - Advanced age (age 55 or over) represents the point where age significantly affects the individual's ability to adjust to other work. There are special rules for persons of advanced age and for persons in this category who are closely approaching retirement age (age 60-64). See Section D.4.d.(1) - Skill Requirements.

c. Education as a Vocational Factor

The term "education" is primarily used in the sense of formal schooling or other training which contributes to the individual's ability to meet vocational requirements (e.g., reasoning ability, communication skills and arithmetic ability). Lack of formal schooling is not necessarily an indication that the individual is uneducated or lacks such capacities. For individuals with past work experience, the kinds of responsibilities assumed when working may indicate the existence of such intellectual capacities although their formal education is limited. Other evidence of such capacities for individuals with or without past work experience may consist of daily activities, hobbies or the results of testing. The significance of an individual's educational background may be affected by the time lapse between the completion of the individual's formal education and the onset of physical or mental impairment(s) and by what the individual has done with his/her education in a work context. Formal education that was completed many years prior to the onset of the impairment(s) or unused skills

and knowledge that were a part of such formal education may no longer be useful or meaningful in terms of the individual's ability to work. Thus, the numerical grade level of educational attainment may not be representative of an individual's present educational competencies which could be higher or lower. However, in the absence of evidence to the contrary, the numerical grade level will be used. The term "education" also indicates whether an individual has the ability to communicate in English, since the ability is often acquired or enhanced through educational exposure. In evaluating the educational level of an individual, the following classifications are used:

(1) **Illiteracy -** refers to the inability to read or write. An individual who is able to sign his or her name, but cannot read or write a simple communication (e.g., instructions, inventory lists), is considered illiterate. Generally, an illiterate individual has had little or no formal schooling.

(2) **Marginal education** - refers to competence in reasoning, arithmetic, and language skills which are required for the performance of simple, unskilled types of jobs. Generally, formal schooling at a grade level of sixth grade or less is considered a marginal education.

(3) **Limited education -** refers to competence in reasoning, arithmetic, and language skills which, although more than that which is generally required to carry out the duties of unskilled work, does not provide the individual with the educational qualifications necessary to perform the majority of more complex job duties involved in semi-skilled or skilled jobs. Generally, a seventh grade through eleventh grade level of formal education is considered a limited education.

(4) **High school education and above** - refers to competence in reasoning, arithmetic, and language skills acquired through formal schooling at a level of grade twelve or above. Usually, these educational capacities qualify an individual for work at a semi-skilled through a skilled level of job complexity.

(5) **Inability to communicate in English** - may be considered a vocational handicap because it often narrows an individual's vocational scope. For example, the inability to communicate in English, the dominant language of the national economy, may preclude an individual from performing jobs which require conversing with peers and supervisors in English, or reading instructions, signs, forms, etc., which are printed in English. However, the inability to communicate in English in no sense implies that an individual lacks formal schooling or intelligence. A person

unable to communicate in English may have a vocational handicap which must be considered in assessing what work the individual can do. The particular non-English language in which an individual is fluent is generally immaterial.

d. Work experience as a vocational factor.

"Work experience" means skills and abilities an individual has acquired through work previously performed. The type of work the individual has already been able to do shows the kind of work s/he may be expected to do. Work experience is relevant when it was done within the last 15 years, lasted long enough for the individual to learn to do it, and was considered substantial gainful activity. Work performed 15 years or more prior to the date of application is ordinarily not considered vocationally relevant. An individual who has no prior work experience (e.g., housewife) or has worked only sporadically for brief periods of time during the 15-year period may be considered to have no relevant work experience. Any skills acquired through work experience are vocational assets unless they are not transferable to other skilled or semi-skilled work within the individual's current capacities. When acquired skills are not transferable, the individual is considered capable of only unskilled work. (See Policy 30 for explanation of transferability of skills.) An individual need not have work experience to qualify for unskilled work because it requires little or no judgment and can be learned in a short period of time.

(1) **Skill requirements**

For purposes of assessing the skills reflected by an individual's work experience and of determining the existence in the national economy of work the individual is able to do, occupations are classified as unskilled, semi-skilled, and skilled. These terms are used in the following manner:

(a) Unskilled work is work which requires little or no judgment to do simple duties that can usually be learned on the job within 30 days. This job may or may not require considerable physical strength. A person does not gain work skills by doing unskilled jobs.

(b) Semi-skilled work requires some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex

than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary as when hands or feet must be moved quickly to do repetitive tasks.

(c) Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality or quantity of material to be produced. Skilled work may require laying out of work, estimating quality, making precise measurements, reading blueprints, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(2) **Transferability of skills**

(a) **Definition -** An individual is considered to have transferable skills when the skilled or semi-skilled work activities that he/she did in past relevant work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs. Transferability depends largely on the similarity of occupationally significant work activities among jobs. Transferability of skills cannot be derived from the performance of job tasks in unskilled work.

(b) **Determination of skills that can be transferred -** Transferability is most likely among jobs in which:

(i) The same or a lesser degree of skills is required;

(ii) The same or similar tools and/or machines are used;

(iii) The same or similar materials, products, processes, or services are involved; and

(iv) The work is in the same or closely related industry.

(c) **Degrees of transferability** - There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all the above factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting that they are not readily usable in other industries, jobs, and

work settings, these skills may be considered not transferable.

(d) **Transferability of skills for individuals of advanced age** - In the case of an individual of advanced age (55 or older) with a severe impairment(s) limiting him/her to sedentary or light work, the individual will be found to be unable to make an adjustment to other work unless he/she has skills that can transfer to other skilled or semiskilled work (or unless the individual recently completed education which provides for direct entry into skilled work) that he/she can do despite his/her impairment(s). A decision as to whether the individual has transferable skills will be made as follows. If the individual is of advanced age and has a severe impairment(s) that limits him/her to no more than sedentary work, the individual will be found to have skills that are transferable to skilled or semiskilled sedentary work only if the sedentary work is so similar to the individual's previous work that he/she would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See Section D.4.a.(1)(a) and Rule 201.00(f) of Appendix II.) If the individual is of advanced age but has not attained age 60, and has a severe impairment(s) that limits him/her to no more than light work, the rules in paragraphs (2) (a)-(c) of this section will be applied to decide if the individual has skills that are transferable to skilled or semiskilled light work (see Section D.4.a.(1)(b)). If the individual is closely approaching retirement age (age 60-64) and has a severe impairment(s) that limits him/her to no more than light work, the individual will be found to have skills that are transferable to skilled or semiskilled light work only if the light work is so similar to the individual's previous work that he/she would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See Section D.4.a.(1)(b) and Rule 202.00 (f) of Appendix II.)

(e) **Residual Functional Capacity (RFC)** - Reduced RFC will limit the number of jobs within an A/R's physical or mental capacity to perform and will impact upon the degree to which acquired skills may be considered transferable. All functional limitations, both exertional and non-exertional, must be considered in determining transferability of job skills.

(f) **Evaluation of transferability of skills** - This evaluation is made when consideration is given to whether an individual is able to do any other work, taking into account the individual's age, education, past

work experience and residual functional capacity. The Medical Vocational Rules in Appendix II are used for this purpose.

In certain instances, these rules indicate that if the individual has transferable skills, he/she will be determined not disabled and if the individual does not have transferable skills, he/she will be considered disabled. The Dictionary of Occupational Titles (DOT) and Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles should be used to determine if there are other jobs that this individual can do using transferable skills. The DOT includes a comprehensive description of job duties and related information for nearly all jobs that exist in the national economy. It groups occupations into a classification structure based on interrelationships of job tasks and requirements. The Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles provides supplemental information about jobs including physical demands, environmental conditions and specific vocational preparation time.

The procedure used to determine if there are other jobs an individual can do using transferable skills is as follows:

(i) Consult the Alphabetical Index of the DOT to obtain the DOT code number of the individual's past job.

(ii) Using the DOT code number, locate in the Occupational Group Arrangement Section of the DOT the job description of the past job which includes the main work activities of the job.

(iii) Using the same DOT code number, consult Part B of Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles to find the physical exertion level of the past job and to obtain the Guide for Occupational Exploration (GOE) code number.

(iv) Using the GOE code number, turn to Part A of Selected Characteristics.. to ascertain the physical demands, environmental conditions, and specific vocational preparation (SVP) of the individual's past job.

(v) Using both of the above mentioned books, determine if there are at least three jobs that this individual can do. An

individual can not be expected to do any job that has a higher physical demand level or skill level than his/her past job or to do a job that has a skill level less than 3. Individuals are not expected to do more complicated jobs than they have actually performed in the past or perform a job that takes longer to learn or is more complex in regard to data, people or things than a past job. The more similar a job is to the individual's past job in the use of tools, machines or materials, in the products or services involved, and in the type of industry, the more likely that the individual can transfer acquired skills to a new job.

(3) **Work which exists in the national economy**

Work exists in the national economy when it is present in significant numbers either in the region where the individual lives or in several other regions of the country. It does not matter whether there is such work in the immediate area in which the individual lives, whether there is a specific job vacancy for the individual, or whether the individual would be hired if he/she applied for the job. A finding that work exists in the national economy is made when there is a significant number of jobs (in one or more occupations) having requirements which do not exceed the individual's physical or mental capabilities and vocational qualifications. Isolated jobs of a type that are present only in very limited numbers in relatively few geographic locations outside of the region where the individual resides are not considered to be "work which exists in the national economy." An individual will not be denied disability status on the basis of these kinds of jobs. If work that the individual can do does not exist in the national economy, the individual shall be determined disabled. If such work does exist in the national economy, the individual will be determined not disabled.

An individual will be determined not disabled if his/her functional capacity and vocational abilities make it possible for the individual to do work which exists in the national economy but the individual remains unemployed because of:

(a) Inability to obtain such work;

(b) Such work does not exist in the individual's local area;

(c) The hiring practices of employers;

(d) Technological changes in the industry in which the individual has worked;

(e) Cyclical economic conditions;

(f) No job openings for the individual; or

(g) The individual does not wish to do a particular type of work.

5. **Responsibilities of Disability Review Team**
Department Regulation 360-5.2

a. The Disability Review Team must review the individual's entire case record, including both medical and social records, and reach one of the following decisions. Particular attention should be given to the treating physician's opinion. A complete discussion of how medical opinions should be weighed can be found in Section D.3.e.(1).

(1) **Approval -** The individual is determined disabled and is placed in one of the following classifications:

(a) **Group I** includes individuals who show no possibility of engaging in any substantial gainful work activity because they have a physical and/or mental impairment(s) which is disabling and considered to be irreversible.

A Group I certification shall apply for the life of the individual to age 65 with the following exceptions:

(i) the case is closed for 12 months or more (See Section H regarding the reapplication process);

(ii) the individual shows medical improvement; or

(iii) the individual returns to work which is considered substantial gainful activity.

(b) **Group II** includes individuals who have impairments which, while totally disabling at the time of determination, are expected

to show an improvement in physical and/or mental status which will enable them to become capable of substantial gainful activity. Some reasons for this improvement may be: the condition may be arrested; a remission may occur; therapeutic advances are occurring; and rehabilitation is deemed feasible.

(2) **Disapproval -** The individual does not meet the disability criteria set forth in this manual.

(3) **No Action -** This decision is made when there is not adequate medical and/or social information to determine if the individual is disabled.

b. The DSS-639, Disability Review Team Certificate, must be completed for all cases reviewed by the Disability Review Team. Information on this form includes the decision, the rationale and regulatory citations for approval or disapproval, the effective date of disability, and the expiration date for Group II cases. If the decision is No Action, the Review Team shall request the specific medical and/or social information needed to complete the disability review. A copy of this form and direction for completion are found on Forms and Publications 1 and 2.

c. The "Psychiatric Review Technique Form" (PRTF) DSS-3818 is a suggested form which may be completed at the discretion of the district for cases which include a psychiatric diagnosis. A copy of this form and directions for its completion are found on Forms and Publications 13-21. The PRTF is designed to ensure that all pertinent mental diagnoses are evaluated as necessary, that adequate documentation has been obtained, and, if a case cannot be approved on the basis of meeting a listing, that a mental residual functional capacity assessment is done. For those districts which choose not to use the PRTF, it is imperative that the documentation in item 10 of the "Disability Review Team Certificate" (DSS-639) reflect that the pertinent mental diagnosis(es) has been fully developed, that all medical and nonmedical evidence pertinent to the mental diagnosis(es) has been considered, and that the sequential evaluation process has been followed. All diagnoses/listings on which the decision is based should be addressed, as well as whether the A/R's impairment(s) meets or equals the listing(s); if so, the specific subsections should be indicated.

In psychiatric cases in which no listing is met or equaled, it may be necessary to complete a "Mental Residual Functional Capacity Assessment" DSS-3817 (please refer to Forms and Publications 23-25). If a mental residual functional capacity assessment is utilized, the specific areas in which the A/R's functional capacity is limited should be noted on the DSS-639. The rationale should

address the findings, conclusions and the decision.

d. The Disability Review Team shall establish the effective date of disability in accordance with Section D.6. The effective date is the first day of the month in which the individual meets the disability criteria and not earlier than 3 months prior to the month of application for Medicaid.

e. The Disability Review Team must maintain statistics as to the number and disposition of the cases reviewed. Form DSS-2336, "Review Team Quarterly Statistics Report", should be completed quarterly and mailed to the address printed on the back of the form. (See Exhibit 2 for the form and instructions for its completion.)

f. When a case is submitted for redetermination, the Disability Review Team must determine if an individual's disability continues by using the Continuing Disability Review (CDR) process set forth in this manual. If disability continues, the case is classified either Group I or Group II. If the case is classified Group II, a new expiration date is given based on how long the disability is expected to last. This certification period can be for less than or greater than 12 months.

6. **Effective Date of Disability**
Department Regulation Section 360-5.8

An effective date of disability shall be established by the Disability Review Team for each individual who is determined disabled. It is important to establish the effective date of disability as early as possible. The following guidelines should be used in determining this date:

a. **Initial Certification** - The effective date of disability cannot be more than three months prior to the month of application for Medicaid for initial certification. In order for the effective date to be established three months prior to the month of application, medical evidence must indicate that the individual was disabled during that period.

Most cases will be approved for a period of at least 12 months. It is, however, important to note the distinction between the disability **onset** date, which refers to the date on which the A/R actually meets the disability criteria, and the disability **effective** date, which refers to the date from which the A/R is approved for disability for Medicaid purposes. There are cases in which the onset of the A/R's disability is prior to the earliest possible Medicaid effective date (i.e., onset date is more than three months prior to the date of application), and in which the A/R's disability has lasted or may be expected to last less than 12 months after

this effective date. An example is as follows:

John Doe is a 29 year-old male who was involved in a motor vehicle accident in June of 1998 and suffered a fractured femur. He was hospitalized for ten days, during which time he had surgery to repair the femur. Due to complications during recovery, he found it necessary to apply for Medicaid on March 1,1999. Documentation from his physician indicated that he met disability criteria from the time of the accident (onset date June 1998), and it was anticipated that Mr. Doe would be able to return to work as of June 1, 1999. Based on this, the client was approved for disability from December 1, 1998 (effective date three months retroactive from date of application) until May 31, 1998, as it was determined that he would be able to return to work on June 1, 1999.

In such a case, the client's impairment could be expected to last for a continuous period of 12 months (June 1, 1998-May 31, 1999) and therefore, the duration requirement was met. As the other disability criteria were also met, the client was approved for a period of less than 12 months from the effective date to the expiration date.

For these cases, the following procedure should be followed:

(1) On Form DSS-639, "Disability Review Team Certificate", the reviewer should note in the appropriate field the effective date and, in addition, write in the words "onset date" with the date of disability onset.

(2) On Form DSS-639, Item 10, the reviewer should note the period for which the A/R is determined disabled from the date of onset, in order to clearly document that the duration requirement has been met.

b. S/CC Recipients (single individuals and childless couples receiving Medicaid with Safety Net cash assistance or Medicaid-Only) – Generally, the effective date should be the first day of the month in which the individual became disabled based on the criteria in this manual. This date should be no earlier than three months prior to the month of initial application for Medicaid. An effective date of disability can be established during a prior authorized period for S/CC-related recipients who have been continuously eligible. If the effective date of disability covers a prior authorized period, an adjustment for medical care and services under the SSI-related category shall be made.

(1) Mr. X received Public Assistance from January 1, 1998 through December 31, 1998. When the case was closed in December, Mr. X applied for Medicaid-Only and was determined by the Disability Review Team as disabled with an effective date of January 1, 1998. Funding should be claimed retroactively under the SSI-related category from the effective date of January 1, 1998.

(2) Mr. Y has been in receipt of Medicaid as S/CC - related from July, 1996 until the present. The Disability Review Team determines that Mr. Y has been disabled since October 1998. As in the example above, funds under the SSI-related category shall be claimed for medical care only from the effective date of disability, which is October 1998.

c. SSI Recipients - SSI recipients in New York State are automatically eligible for Medicaid. To determine the effective date of disability for these individuals, the following fields on the SDX should be screened:

(1) Field 317 "Payment Status Code". If the code CO1 appears, the individual is in payment status. If the code NO1 appears, the individual is in Non Pay status due to excess countable income.

(2) Field 98 "Onset-Disability/Blindness Code". For the clients who have been determined disabled, this code will give the effective date of disability onset.

NOTE: For SSI recipients with medical bills incurred up to three months prior to month of application, refer to Section I.

7. **Expiration Dates**

All Group II cases must have an expiration date. The expiration date must be at least 12 months from the effective date (or onset date) for the initial disability period. Cases may be approved for more than 12 months whenever the medical evidence warrants a longer disability period. The Disability Review Team should consider the facts of the case (such as the client's diagnoses, medical history and findings, extent of functional impairment, age, work history, etc.) when setting the expiration date. A maximum of seven years is recommended for the most severely disabled Group II cases.

Group II cases must be re-evaluated for continuing disability before the expiration date. Such cases may, if appropriate, be recertified for less than one year since the 12- month duration requirement has already been fulfilled.

Some of the medical impairment listings in Appendix I contain specified lengths of time to approve cases when certain specific criteria are met. Examples are listings for heart or kidney transplants, acute leukemia, liver disease, and cancer. Cases approved on the basis of HIV-related illness may be approved for up to seven years, if appropriate.

E. **Vocational/Financial Considerations**

1. **Substantial Gainful Activity (SGA)**
Department Regulation Section 360-5.2

a. Definition - Substantial gainful activity is work activity that is both substantial and gainful as detailed below.

(1) Substantial work activity is work that involves doing significant physical and/or mental activities. Work can be considered substantial even if performed part-time and/or requires less responsibility than former work.

(2) Gainful work activity is work done for pay or profit, whether or not a profit is realized.

(3) Other activities such as household tasks, attending school, therapy, hobbies, club activities or social programs generally are not considered substantial gainful activity.

b. Evaluation Guidelines

In determining whether or not an individual, who is not statutorily blind, is able to do work at the substantial gainful activity level, the following factors shall be considered on the basis of medical and vocational evidence:

(1) **Nature of Work** - The performance of duties by the individual which involve the use of his/her skills or experience, supervision and responsibility, or contribute substantially to the operation of a business is evidence indicating that an individual has the ability to engage in substantial gainful activity.

(2) **Adequacy of performance** - The adequacy of an individual's

performance of assigned work is also evidence as to whether or not he/she has the ability to engage in substantial gainful activity. An individual's failure, due to his/her impairment, to perform ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work may constitute evidence of an inability to engage in substantial gainful activity. Performance of work that involves minimal duties that make little or no demands on the individual and are of little or no use to his/her employer does not demonstrate ability to engage in substantial gainful activity.

(3) **Special employment conditions** - Work performed under conditions of employment which makes special provision for an employee's impairment (for example, work in a sheltered workshop or in a hospital by a patient) may provide evidence of skills and abilities that demonstrate an ability to engage in a substantial gainful activity, whether or not such work in itself constitutes substantial gainful activity.

(4) **Time spent in work** - The amount of time spent in work is important but shall not be the sole basis for determining whether an individual is able to do substantial gainful activity. Evaluation as to whether the work is substantial and gainful is made regardless of whether the individual spends more or less time at the job than workers who are not impaired and are doing similar work as a regular means of livelihood.

(5) **Earnings from work**

(a) **General** - The amount of gross earnings from work activities (minus appropriate impairment-related work expenses as set forth on Policy 42) may establish that the individual has the ability to engage in substantial gainful activity. Generally, activities which result in substantial earnings would show that the individual is able to do substantial gainful activity. However, the fact that the earnings are not substantial does not necessarily show that an individual is not able to do substantial gainful activity. Where an individual is forced to discontinue work activities after a short time due to an impairment, the earnings from such work do not demonstrate ability to engage in substantial gainful activity.

(b) **Subsidized earnings** - If an individual's earnings are being subsidized, the amount of the subsidy is not counted when determining whether or not work is substantial gainful activity. Where work is done under special conditions (e.g., an impaired

person who does simple tasks under close and constant supervision), only the part of the pay which is actually "earned" is considered. An employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If the employer does not set the amount of the subsidy, a decision by the agency shall be made as to the reasonable value of the work.

(c) **Earnings at a monthly rate in excess of $860** - An individual's gross earnings from work activities averaging $860 or more a month shall be deemed to demonstrate the ability to engage in substantial gainful activity in the absence of evidence to the contrary. Effective January 1, 2006, the SGA level was increased from $830 to $860. Regulations provide for an annual automatic cost of living adjustment to this amount. An individual is generally considered not to be engaged in substantial gainful activity (SGA) if his/her earnings are less than the SGA level, unless there is evidence to the contrary.

(d) **Factors considered when an individual is self-employed -** The earnings or losses of a self-employed individual often reflect factors other than the individual's work activities in carrying on his/her business. For example, a business may have a small income or may even operate at a loss even though the individual performs sufficient work to constitute substantial gainful activity. Thus, less weight shall be given to such small income or losses in determining a self-employed individual's ability to engage in substantial gainful activity and greater weight shall be given to such factors as the extent of his/her activities and the supervisory, managerial, or advisory services rendered by the individual.

(e) **Impairment-related work expenses** – Impairment related work expenses which, due to an individual's impairment(s), are expended to enable the individual to work shall be deducted in determining an individual's countable earned income and in deciding if s/he has done substantial gainful activity. These expenses must be paid by the disabled individual. No deduction will be allowed to the extent that payment has been or will be made by another source. The costs are deductible even though the items and services are also needed to carry out daily living functions unrelated to work.

The following are deductible impairment-related work expenses:

(i) Assistance in traveling to and from work or while at work, assistance with personal functions (e.g., eating, toileting), or with work-related functions (e.g., reading, communicating).

(ii) Assistance at home with personal functions, (e.g., dressing, administering medications) in preparation for going to and returning from work. Payments made to a family member for attendant care services may be deducted only if such family member, in order to perform the services, incurs an economic loss by terminating his/her employment or by reducing the number of his/her work hours.

(iii) Medical devices such as wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(iv) Prosthetic devices such as artificial replacements of arms, legs and other parts of the body.

(v) Work-related equipment such as one-hand typewriters, telecommunication devices for the deaf, Braille devices, and specially designed work tools.

(vi) Residential modifications in the form of changes to the exterior of his/her home to permit the individual to get to his/her means of transportation (e.g., exterior ramps, railings, pathways).

(vii) For a person working at home, modifications to the inside of his/her home in order to create a working space to accommodate an impairment (e.g., enlargement of a doorway leading into the office, modification of work space to accommodate problems in dexterity). For a self-employed person, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(viii) Devices or appliances which are essential for the control of a disabling condition either at home or in the work

setting and are verified as medically necessary (e.g., electric air cleaner for an individual with severe respiratory disease who cannot function in a non-purified air environment).

(ix) Drugs or medical services including diagnostic procedures needed to control the individual's impairment. The drugs or services must be prescribed or used to reduce or eliminate symptoms of the impairment or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

Some examples of deductible drugs and medical services are: anticonvulsant drugs, antidepressant medication for mental disorders, radiation treatment or chemotherapy, corrective surgery for spinal disorders, and tests to determine the efficacy of medication.

(x) Expendable medical supplies such as catheters, elastic stockings, bandages, irrigating kits, incontinence pads, face masks and disposable sheets and bags.

(xi) Physical therapy required because of an impairment and which is needed in order for the individual to work.

(xii) Costs of a seeing-eye dog, including food, licenses and veterinarian services.

(xiii) Payments for transportation costs in the following situations:

-Costs of structural or operational modifications to a vehicle required by an individual in order to get to and from work;

-Mileage allowance for an approved vehicle limited to travel related to employment; and

-Cost of driver assistance or taxicabs where such special transportation is not generally required by an unimpaired

individual in the community.

2. **Trial Work Period**

a. Trial Work Period is a period during which an individual may test his or her ability to work and still maintain disability status. During a trial work period an individual, who is still medically impaired, may perform "services" in as many as nine (9), not necessarily consecutive, months.

b. "Services" in this section means any activity in employment or self-employment for pay or profit, or the kind of activity normally done for pay or profit. Work activity will be considered "services" if in any month the individual earns $620 or more. (New federal regulations provide for an annual automatic cost of living adjustment to this amount.) For self-employed individuals, work will be determined to be "services" only when the individual's monthly net earnings are more than the SGA level or when the individual works more than 80 hours a month in his/her business.

Work is generally not considered to be "services" for the purpose of calculating trial work period months if the work is:

(1) Part of a prescribed program of medical therapy;

(2) Carried out in a hospital under the supervision of medical and/or administrative staff;

(3) Not performed in an employer-employee relationship; or

(4) Not normally performed for pay or profit.

c. The Disability Review Team may find that the individual's disability has ended at any time during the trial work period if the medical or other evidence shows that he/she is no longer disabled. An individual may have only one trial work period during a disability period.

3. **Plans for Achieving Self-Support (PASS)**
Department Regulation Section 360-4.6

Eligible blind and disabled individuals may participate in Plans for Achieving Self-Support. These plans are intended to assist certain A/Rs to accumulate money and/or set aside current resources in excess of the allowable resource level for use in accordance with a plan. The purpose of the PASS is to assist these individuals in

obtaining or regaining a feasible occupational objective. The individual may be in, or be a candidate for an occupational training program, purchase occupational equipment, or establish a business, etc.

a. Conditions for Plans for Achieving Self-Support (PASS)

After application of all disregards for blind or disabled individuals under 65, or for blind or disabled individuals age 65 or over who received SSI payments or aid under the State Plan for the blind or disabled for the month before the month in which the individual attained age 65, any remaining countable income and resources may be set aside for a Plan to Achieve Self-Support (PASS).

A PASS must meet the following conditions:

(1) A specific plan for self-support must contain a feasible designated occupational objective and must exist in writing;
(2) The local Commissioner of Social Services must approve the plan and any subsequent plan changes;

(3) The individual plan must contain specific savings and/or planned disbursements for the designated occupational objective;

(4) The plan must provide for the identification and segregation of money and goods if any, being accumulated and conserved for the purpose of achieving the feasible occupational objective;

(5) The plan must be current;

(6) The individual must be performing in accordance with the specific plan; and

(7) An approved plan is limited to 18 months with the possibility of an extension for an additional 18 months. A further extension of 12 months may be allowed in order to fulfill a plan for a lengthy education or training program.

b. Acceptable Candidates for Plans for Achieving Self-Support (PASS)

Not all A/Rs would be appropriate candidates for a self-support plan. Agencies should take care in selecting who should be considered for a self-support plan. PASS should only be used for A/Rs who, through rehabilitative efforts, can reasonably be expected to become self-supporting or more self-supporting and

demonstrate a reduction in medical expenses paid through Medicaid. Whether the individual is eligible for occupational rehabilitation is an important factor in determining if a PASS is appropriate. A self-support plan may be used for an individual in a long term care facility or the community.

In cases where both spouses are blind or disabled, each may have an active plan for achieving self-support. In such a situation, a plan should be developed for each spouse independent of the plan for the other party.

Some objectives that an individual may be striving to meet which are acceptable for self-support plans are:

(1) Saving money for a future down payment on a specially equipped vehicle to be used by the individual for daily transportation to his/her prospective place of employment;
(2) Accumulating money to start a small business which is applicable to the individual's occupational background and/or training;

(3) Accumulating funds so the individual may continue his/her education; or

(4) Another occupational goal which would make the individual more self-sufficient and will lessen the person's need for Medicaid.

c. Selection of PASS Participants

The local agency should consider all A/Rs who appear to have the potential to benefit from a PASS. Additionally, A/Rs may request that they be considered for a PASS. In all instances, the local commissioner has the authority to approve or reject all plans and any subsequent changes to plans for self-support for individuals under his/her jurisdiction.

A decision as to whether the PASS is approvable should be reached as quickly as possible using all available information, and the individual must be notified of the decision in writing.

d. Initiation of a Plan for Achieving Self-Support

To initiate a PASS the following steps shall be taken:

(1) At certification and recertification, if the local district identifies a disabled A/R with the potential for rehabilitation and if the A/R wants these services, the worker should make any necessary referrals. This referral may be made

even if the A/R is already in a training program.

(2) The local district worker will make a written evaluation of the A/R after conducting a personal interview with the individual. If the A/R is institutionalized or is in a supervised residential setting, a conversation with a facility social worker or case manager who is familiar with the individual should be held.

(3) If the A/R is already in a training program, the local district worker will assist the individual in writing a self-support plan utilizing a PASS outline or a local equivalent.

(4) If the A/R is not in a training program and the worker is of the opinion that a PASS is indicated, a referral to Office of Vocational Rehabilitation, Commission for the Blind and Visually Handicapped or the Veteran's Administration, etc. should be made. The servicing agency such as one of the above should make an in-depth medical/vocational evaluation of the individual.

(5) When this evaluation is completed and a feasible occupational objective is indicated, the worker may assist the individual in writing a PASS. The service agency may also be able to provide assistance in preparing a PASS.

(6) The amount of money to be set aside to fulfill the PASS shall be clearly identified. Separate accounts shall be established for the money with an indication that the account is for a PASS.

(7) Once the PASS is approved and signed by the local Commissioner of Social Services, the worker, and the individual involved, the plan is in effect.

(8) Every three months, a report that indicates how the individual is progressing shall be written to verify that the individual is saving and/or applying the prescribed amount of money stated in the plan and acting in accordance with all other provisions of the plan. All evaluations, PASS outlines and other information shall be filed in the individual's case folder.

(9) The PASS may be terminated as soon as the agency becomes aware of non-compliance with the plan and a satisfactory explanation is not provided. In all instances, if the individual fails to comply with the PASS for a period of three months, the plan will be deemed to have been abandoned as of the date when performance in accordance with the plan stopped. The local agency shall re-determine the individual's eligibility for Medicaid.

A PASS may be altered if the individual can no longer fulfill the terms of the plan due to illness or change in circumstances. Such alterations or revisions are subject to approval by the local Commissioner of Social Services. Where the feasible occupational objective is changed, the revised approved plan should take into consideration any training already received and should be promptly reviewed.

(10) Upon satisfactory completion of the plan, the earmarked funds must be utilized as planned, within a reasonable length of time. If the individual refuses to use the funds as planned, the agency should consider these funds as an available resource and/or income. The individual's financial eligibility for Medicaid should be redetermined at this point.

e. Notices Related to Plans for Achieving Self-Support (PASS)

The local district shall review the A/R's plan for achieving self-support, along with any other relevant information, and determine whether or not the PASS is approvable. The district must notify the A/R of its determination in writing. The notice to the A/R must include the following information:

(1) A statement that the request for a PASS has been approved or denied.

(2) If approved, the notice must identify the designated occupational objective, the specific savings and/or planned disbursements for the objective and the approved period of time for achieving the objective.

(3) If denied, the notice must detail the reason(s) for the denial.

(4) An explanation of the A/R's right to a fair hearing if he/she disagrees with the agency's decision regarding the PASS denial or any aspect of the agency's PASS approval.

(5) All other information required to be included with the agency's Notices of Intent.

If the PASS approval or denial affects the A/R's eligibility for Medicaid the local district shall send the appropriate notice(s) informing the individual of this information.

F. Disability Determination for Clients Under 21 Years Old

Children who are determined disabled may be eligible for Medicaid as SSI-related using the SSI-related budgeting deductions and disregards. In some cases the SSI-related methodology may be more beneficial than other methodologies, especially if there is earned income that is deemed to the child. Children with severe impairments who may be disabled should be referred to the Social Security Administration to apply for SSI benefits.

A child under the age of 18 who is not engaged in substantial gainful activity may be considered disabled if he/she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and that is expected to meet the 12-month duration requirement or result in death. The children's medical impairment listings are used for individuals under the age of 18 and are found in Appendix 1 Part B. The adult listings in Appendix 1 Part A may be used for children in circumstances when the children's medical listings do not give appropriate consideration to a particular disease process in childhood. Children who have been certified disabled must be re-evaluated under the adult criteria upon attainment of age 18.

The medical review process for children is described in Section M. Suggested forms for collecting information from parents, caretakers, schools and medical sources are found in the Forms and Publications Section.

G. Continuing Disability Review Process (CDR) for Adults

1. **General -** All disability cases, classified as Group II, must be reviewed by the Disability Review Team prior to the disability expiration date to determine if the individual continues to be disabled.

   A number of factors are considered in determining if disability continues. It must be determined if there has been medical improvement in the individual's impairment(s) and if so, whether this medical improvement is related to his/her ability to work. If there has been no medical improvement, the Disability Review Team must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to the individual's ability to work has not occurred and no exception applies, the individual's disability will continue. Even where medical improvement related to the individual's ability to work has occurred or an exception applies, it must also be shown that the individual is currently able to engage in substantial gainful activity before he/she can be found to no longer be disabled.

A determination of medical improvement in itself never constitutes reason to find that disability has ended. However, a determination that there has been no medical improvement can be the basis for determining that disability continues as long as none of the exceptions apply.

The Continuing Disability Review process consists of specific steps that are set forth in detail below. The Continuing Disability Review Process for children under 18 can be found in Section M 6.

2. **Medical Improvement**

a. Definition - Medical improvement is any decrease in the medical severity of the individual's impairment(s) which was present at the time of the most recent favorable medical decision that the individual was disabled or continued to be disabled. This decrease in medical severity must be based on medical evidence showing changes in the signs, symptoms and/or laboratory findings associated with the individual's impairment(s). Minor changes in signs, symptoms and laboratory findings that obviously do not represent medical improvement may be disregarded. A determination that there has been a decrease in medical severity must be based on changes, (improvement in), signs, symptoms and laboratory findings.

b. Medical Improvement Related to Ability to Work

(1) Medical improvement is not related to the individual's ability to work if there has been a decrease in the severity of the impairment(s), as defined in (a) above, but no increase in the individual's functional capacity to do basic work activities.

If there has been medical improvement in the individual's impairment(s) but the improvement is not related to his/her ability to do work and none of the exceptions (as set forth below) applies, the individual continues to be disabled.

(2) Medical improvement is related to the individual's ability to work if there has been a decrease in the medical severity, as defined in this section and an increase in the individual's functional capacity to do basic work activities as discussed below.

A determination that medical improvement related to an individual's

ability to do work has occurred does not necessarily mean that his/her disability will be found to have ended unless it is also shown that he/she is currently able to engage in substantial gainful activity as discussed in this manual.

c. Functional Capacity to do Basic Work Activities - In order to determine how and to what extent the individual's impairment(s) has affected his/her ability to do work, consideration must be given to how his/her functional capacity for doing basic work activities has been affected. Basic work activities mean the abilities and aptitudes necessary to do most jobs. Included are: exertional abilities such as walking, standing, pushing, pulling and reaching; and nonexertional abilities and aptitudes such as seeing, hearing, speaking, handling, remembering, using judgment, and dealing with supervisors and co-workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels and would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment usually results in some limitation of the functional capacity to do one or more of these basic work activities. Residual functional capacity is what physical and/or mental work-related activity an individual can do despite his/her impairment(s)/limitations. (See Policy 32.) It is this residual functional capacity in conjunction with the individual's age, education and work experience that is used to determine whether the individual can still do his/her past relevant work or any other work.

(1) A decrease in the severity of an impairment as measured by changes in signs, symptoms or laboratory findings can result in an increase in the individual's functional capacity to do work activities. When new evidence showing a change in signs, symptoms, and laboratory findings establishes that both medical improvement has occurred and the individual's residual functional capacity has increased, medical improvement which is related to ability to do work has occurred. If so, the residual functional capacity assessment is also used to determine whether the individual can engage in substantial gainful activity and thus, whether the individual continues to be disabled.

(2) Many impairment related factors must be considered in assessing the individual's functional capacity for basic work activities. Age is one factor in the sense that there is a gradual decrease in organ function with age as well as a decrease in range of motion, muscle atrophy, and changes in the cardiac and respiratory systems which limit an individual's exertional range.

(3) The longer an individual is away from the work place and is inactive, the more difficult it becomes to return to ongoing gainful employment. A gradual change occurs in most jobs so that after 15 years, it is no longer realistic to expect that the skills and abilities acquired in these jobs will continue to apply to the current workplace. If the individual is 50 years of age or older and has been determined disabled for a considerable period of time, this factor along with his/her age will be considered in assessing the individual's residual functional capacity.

d. Ability to Engage in Substantial Gainful Activity - In most instances, before an individual's disability can be discontinued, it must be shown that he/she is able to engage in substantial gainful activity. To do this, all current impairments must be considered, not just the impairment(s) present at the time of the most recent favorable determination.

e. Point of Comparison - For purposes of determining whether medical improvement has occurred, the medical severity of the impairment(s), which was present at the time of the most recent favorable medical decision, shall be compared to the current medical severity of that impairment(s). If medical improvement has occurred, the Disability Review Team shall compare the individual's current functional capacity to do basic work activities based on the previously existing impairment(s) with his/her prior functional capacity in order to determine whether the medical improvement is related to the individual's ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence whereby the individual was determined disabled or to have a continuing disability.

f. Previous Impairment Met or Equaled Listing - If the most recent favorable decision was based on the fact that the individual's impairment(s) at the time met or equaled the Listing of Impairments in Appendix I, an assessment of his/her residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make the most recent favorable decision, it will be found that the medical improvement was related to his/her ability to work. Before finding that the individual's disability has ended, it must be established that he/she can currently engage in substantial gainful activity.

g. Prior Residual Functional Capacity Assessment - If the most recent favorable decision was based on a residual functional capacity (RFC) assessment and not on the fact that the impairment met or equaled a listing, and if there has been a decrease in the severity of the individual's prior impairment(s), an evaluation

must be made as to whether medical improvement is related to ability to work. This is done by comparing the prior and current RFC of the individual. The RFC assessment used in making the most recent favorable medical decision will be compared to the RFC assessment based on current evidence to determine if the individual's functional capacity for basic work activities has increased. There shall be no attempt made to reassess the prior RFC.

If the most recent favorable medical decision should have contained an assessment of the individual's residual functional capacity but does not, either because this assessment is missing from the file or was not done, the Review Team must reconstruct the individual's prior RFC. This reconstructed RFC shall accurately and objectively assess the individual's capacity to do basic work activities. The maximum functional capacity consistent with the favorable decision should be assigned.

h. Basis for Review Team's Decision - The decision as to whether the individual continues to be disabled shall be made on a neutral basis. It should be made without any initial inference as to the presence or absence of disability being drawn from the fact that the individual had previously been determined disabled. All the evidence submitted by the individual as well as all evidence obtained from the treating physician(s) and other sources shall be considered, and the determination as to whether disability continues shall be made on the basis of the weight of the evidence. There must be a comparison of prior and current medical evidence to see if there has been improvement in the signs, symptoms, or findings associated with the impairment(s).

i. Prior file cannot be located - If the prior case record cannot be located, the Review Team shall first determine whether the individual is now able to engage in substantial gainful activity based on all the individual's current impairments. This will allow for a disability determination at the earliest point without addressing the often lengthy process of reconstructing prior evidence.

    (1) If it is determined that the individual cannot engage in substantial gainful activity currently, his/her disability will continue unless one of the second group of exceptions applies. (See Policy 57.)

    (2) If the individual is able to engage in substantial gainful activity, the Disability Review Team will decide whether an attempt shall be made to reconstruct those portions of the missing case record that were relevant to its most recent favorable medical decision. Considerations in this decision will include the potential availability

of old records, whether the source of the evidence is still in operation, and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed, either because it is decided not to attempt reconstruction or because such efforts failed, medical improvement cannot be found. The documentation of the individual's current impairments will provide a basis for any future reviews. If the missing case record is later found, it may serve as a basis for reopening any decision made under this section.

j. Impairment Subject to Temporary Remission - In assessing whether medical improvement has occurred in individuals who have impairments that are subject to temporary remission, the Disability Review Team shall consider the longitudinal history of the impairment(s) including the occurrence of prior remission(s) and prospects for future worsenings. Temporary improvement in such impairments will not warrant a finding of medical improvement.

k. Exceptions to Medical Improvement

(1) First Group of Exceptions - There are certain limited situations when an individual's disability can be found to have ended even though medical improvement has not occurred. If one of the following medical exceptions applies, an evaluation must be made as to whether the individual is now able to engage in substantial gainful activity taking into account all the individual's current impairments, not just those that existed at the time of the most recent favorable medical decision. These exceptions to medical improvement are intended to provide a way of finding that an individual is no longer disabled in the limited situations where, even though there has been no decrease in the severity of the impairment(s), evidence shows that an individual should no longer be considered disabled or never should have been considered disabled.

(a) **Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to his/her ability to work)**. Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased the

individual's ability to do basic work activities. This exception is applied when substantial evidence shows that the individual has been the beneficiary of services which reflect these advances and they have favorably affected the severity of his/her impairment or his/her ability to do basic work activities. This decision shall be based on new medical evidence and a new residual functional capacity assessment. This exception will have limited application.

(b) **Substantial evidence shows that the individual has undergone vocational therapy (related to the individual's ability to work).** Vocational therapy (related to the individual's ability to work) may include, but is not limited to, additional education, training or work experience that improves his/her ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment.

(c) **Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the individual's impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision**. Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairment(s) on the individual's ability to do work. If substantial evidence shows that the individual's impairment(s) is not as severe as was determined at the time of the most recent favorable medical decision due to such new or improved methods, such evidence may serve as a basis for finding that the individual is no longer disabled, if he/she can currently engage in substantial gainful activity.

(d) **Substantial evidence demonstrates that any prior disability decision was in error**. If substantial evidence demonstrates that a prior determination was in error the

exception to medical improvement based on error is applied. This evidence may be in the record at the time any prior determination of disability was made or may be newly obtained evidence which relates to that determination. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made. Examples are if a test result is misread or a Listing in Appendix I or a Medical/Vocational Rule in Appendix II was misapplied.

(ii) At the time of the prior evaluation, required and material evidence of the severity of the individual's impairment(s) was missing. That evidence becomes available upon review and substantial evidence demonstrates that had such evidence been present at the time of the prior determination the individual would have been found to be not disabled.

(iii) Substantial evidence, which is new evidence and relates to the prior determination, refutes the conclusions that were based on the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the individual would have been determined not disabled. A substitution of current judgment for that used in the prior favorable decision shall not be the basis for applying this exception.

(e) **The individual is currently engaging in substantial gainful activity**. If an individual is currently engaging in substantial gainful activity, a consideration of whether the individual is entitled to a trial work period, as set forth in Section E 2, must be made before it is determined that an individual is no longer disabled. It will be found that an individual's disability has ended in the month in which s/he demonstrated his/her ability to engage

in substantial gainful activity (following completion of a trial work period, if applicable).

(2) **Second Group of Exceptions**

The following exceptions may result in a determination that the individual is no longer disabled. In these situations the decision that the individual is not disabled shall be made without a determination that he/she has medically improved or can engage in substantial gainful activity.

(a) **A prior decision was fraudulently obtained**. If it is established that any prior favorable determination was obtained by fraud, the Disability Review Team may find that the individual is not disabled.

(b) **The individual fails to cooperate**. If there is a question about whether an individual continues to be disabled, he/she may be asked to provide the local district with medical and/or other evidence or to go for a physical or mental examination by a certain date. The Disability Review Team will find that disability has ended if the individual fails (without good cause) to do what is asked by the local district.

(c) **The individual cannot be located**. If there is a question about whether an individual continues to be disabled and he/she is unable to be located to resolve the question, the individual's case shall be closed with timely and adequate notice.

(d) **The individual fails to follow prescribed treatment (without good cause) which would be expected to restore the individual's ability to engage in gainful activity.** If treatment has been prescribed which would be expected to restore the individual's ability to work and the individual fails to follow that treatment (without good cause), the individual would be determined not disabled.

3. **Evaluation Steps -** The continuing disability review process consists of specific steps to be used in reviewing the question of whether an individual's disability is to be continued. The review may cease and disability may be continued at any point in the process if it is determined

there is sufficient evidence to find that the individual is still unable to engage in substantial gainful activity. The steps are as follows:

a. If the individual is engaging in substantial gainful activity and has completed any applicable trial work period, he/she will be determined not disabled.

b. If the individual is not engaging in substantial gainful activity and the individual's current impairment(s) or combination of impairments meets or equals a listing in Appendix I, disability shall be found to continue.

c. If there has been medical improvement as defined on Policy 50, the procedures in Step (d) below are followed.

d. If the individual is found to have had medical improvement, it must be determined whether this medical improvement is related to the individual's ability to do work. This is in accordance with Policy 51 (i.e., whether or not there has been an increase in the residual functional capacity based on the individual's impairment(s) that was present at the time of the most recent favorable medical determination). If medical improvement is <u>not</u> related to the individual's ability to work, the procedures in Step (e) below are followed. If medical improvement <u>is</u> related to the individual's ability to do work, the procedures in Step (f) below are followed.

e. If there has been no medical improvement or if the medical impovement is not related to the individual's ability to work, the Disability Review Team shall determine whether any of the exceptions apply. One of the following steps shall be taken:

(1) If none of the exceptions apply, the individual will continue to be found disabled.

(2) If one of the first group of exceptions to medical improvement applies, the procedures in Step (f) below are followed.

(3) If one of the second group of exceptions applies, the individual will be found not disabled. The second group of exceptions to medical improvement may be considered

at any point in this process.

f. If medical improvement is shown to be related to the individual's ability to do work or if one of the first group of exceptions to medical improvement applies, an assessment shall be made of the individual's residual functional capacity. This assessment will be based on the individual's current impairments and the impact of the combination of these impairments on his/her ability to do basic work activities. Through this assessment, the Disability Review Team shall determine whether the individual can still do the work that he/she has done in the past. If the individual can do such work, the individual will be found to be not disabled.

g. If the individual is not able to do his/her past relevant work, an assessment will be made as to whether the individual can do other work considering his/her age, education, and past relevant work experience and residual functional capacity based on his/her current impairment(s). If the individual can do other work, he/she will be found not disabled. If he/she cannot do other work, disability will be found to continue.

H. Reapplication for Medicaid by Certified Disabled Individuals

Department Regulation Section 360-5.4

1. When an individual who has been determined disabled reapplies for Medicaid following the termination of his/her Medicaid for reasons unrelated to his/her disability status (e.g., increased financial income or resources), re-submittal of the case to the Disability Review Team shall be required only in the following circumstances:

   a. Twelve months or more have elapsed since the date of last case closing;

   b. The individual has engaged in substantial gainful work activity in the interim; or

   c. The individual has had a significant change in treatment such as major surgery or a stay in a rehabilitation center or hospital in the interim.

2. Cases reopened as a Group II without review by the Disability Review Team, in accordance with this section, shall be reviewed at the expiration date which had been set before the case was closed. If reapplication of Group II cases occurs subsequent

to the date previously set for review by the Disability Review Team, the local agency shall secure and transmit to the Disability Review Team for adjudication, the prior disability case record and current medical and social information.

I. SSI Applicants and Recipients

Department Regulation Section 360-2.2

1. **Determination of Eligibility of SSI Applicants and Recipients** - The Social Security Administration (SSA) determines and re-determines eligibility for all aged, blind, and disabled applicants and recipients of SSI based on SSI financial and categorical standards. Individuals determined eligible for SSI are automatically eligible for Medicaid.

2. **Local District Responsibilities**- The local agency retains administrative responsibility for other phases of the Medicaid program for these individuals. These functions include, but are not limited to, the following:

   a. Authorize and reauthorize Medicaid for SSI eligible individuals based on the interface between the New York State Automated Eligibility System, the Welfare Management System (WMS) and the State Data Exchange (SDX). This is referred to as the Automated SDX/WMS Interface (ASWI) upstate and the Auto-SDX in New York City.

   b. Issue temporary Medicaid identification cards if necessary;

   c. Determine retroactive eligibility for SSI applicants who have medical bills in the three-month period prior to the month of application for SSI;

   d. Obtain information on third party health insurance from SSI eligible individuals;

   e. Give prior approval, when appropriate, for specified medical services;

   f. Participate with the Social Security Administration in the determination and disposition of recipient fraud; and

   g. Apply adjustment and recovery provisions.

3. **Department Responsibilities** - The Department has the following responsibilities for the Medicaid program for SSI recipients:

   a. Issue Medicaid identification cards (Common Benefit Identification Card) for

SSI eligible individuals;

b. Process medical bills; and

c. Monitor utilization.

4. **Individuals Denied SSI** - In general, individuals who are denied SSI as not being disabled would not be reviewed for Medicaid disability since both programs use the same disability criteria. However, there are instances when a Medicaid disability review is appropriate.

a. Denial by SSI for Other Than Medical Reasons - The basis of the denial can be determined from the SDX. If an individual is denied SSI for other than medical reasons, the following are some of the codes that may appear in Field 317 (Payment Status Code):

(1) N06 - Non-Pay, Recipient failed to file for other benefits.

(2) N17 - Non-Pay, Failure to pursue claim by applicant.

(3) N36 - Non-Pay, Insufficient or no medical data furnished, no visual impairment.

(4) N37 - Non-Pay, Failure or refusal to submit to consultative examination(s), no visual impairment.

(5) N38 - Non-Pay, Applicant does not want to continue development of claim, no visual impairment.

Individuals denied SSI who are in receipt of cash assistance and who claim an impairment or unemployability status must appeal any denial of his/her initial SSI application and exhaust the available administrative remedies.

All other individuals denied SSI should be urged to cooperate with the Social Security Administration in processing their application for SSI. If the individual does not want to pursue his/her SSI application, a Medicaid disability review can be performed.

b. Denial by SSI for Medical Reasons - Individuals denied SSI for medical reasons who are in receipt of cash assistance and who claim an impairment or unemployability status must appeal any denial of his/her initial SSI application

and exhaust the available administrative remedies.

All other individuals denied SSI for medical reasons should be urged to cooperate in the SSI appeals process. An individual may become disabled subsequent to an SSI denial. If an individual's medical condition deteriorates, he/she should be urged to reapply for SSI. For the individual who requests Medicaid-Only, a disability review is appropriate.

5. **Loss of SSI Eligibility** - No disability review is necessary for an individual who loses SSI eligibility for reasons unrelated to his/her medical condition prior to the individual's medical reexamination diary date. This date is the time when SSA was to have reevaluated the individual's medical condition. To obtain the individual's medical re-examination diary date and the reason the individual's SSI benefits were terminated, the local agency should contact the SSA District Office requesting this information.

   If the individual was terminated for other than medical reasons and if there is a medical diary date, the individual can be considered disabled for Medicaid purposes until that date. To certify that the individual remains disabled beyond this date, or if no diary date is available, the local agency must submit the case to the Disability Review Team for a disability review.

6. **SSI Recipients with Medical Bills for Three Months Prior to SSI Eligibility** - The local agency is responsible for determining retroactive eligibility for SSI recipients who have medical bills incurred in the three-month period prior to the month of application for SSI, (three months prior to the Medicaid effective date, field 277 on the SDX, or WMS Screen 5 Medicaid "From" date.) In order to claim funds under the SSI-related category for these medical bills, a disability review and a financial determination is necessary for this three-month period. The local agency should consult the SDX for the disability date.

   Field 98 of the SDX will usually contain the onset date of disability. This date may be earlier than the SSI effective date. If the disability onset date in field 98 covers the three-month retroactive period (or less if coverage is sought for only 1 or 2 months) than a separate Medicaid disability review is not necessary. A separate Medicaid disability review is necessary when the onset date is not found on the SDX, when it does not cover the period requested, or when it can not be otherwise obtained from the SSA office. Medicaid coverage as disabled should occur only when the effective date or onset date of disability is established by either the SSA or the Medicaid Disability Review Team. If a Medicaid disability review is necessary, the agency should use Form DSS-1151, "Disability Interview", to inform the Disability

Review Team that the individual is currently in receipt of SSI, the individual's effective SSI date of disability, and that a disability determination is needed for the three-month retroactive period only. The completed DSS-1151, along with medical documentation covering the retroactive period, should be submitted to the Disability Review Team for a determination of disability in accordance with the procedures detailed in this manual.

J. Substance Addiction Disorders

Department Regulation Section 360-5.10

1. Evaluation of Substance Addiction

Substance addiction disorders are evaluated using listing 12.09 of the listing of impairments in Appendix 1. This listing is a referent listing to several other physical and mental impairment listings. These listings include conditions which frequently involve the behavioral or physical changes associated with the regular use of substances that affect the central nervous system. An individual may not be considered disabled if substance abuse would be a contributing factor material to the decision that the individual is disabled.

Listing 12.09 requires that substance addiction disorders be evaluated under the criteria of one of the 9 referenced listings if the individual has one of the referenced impairments. An individual with a substance addiction disorder may have physical disorders such as liver disease, peripheral neuropathy, or chronic pancreatitis. There may be a mental disorder such as depression, anxiety, organic brain disorder, or personality disorder. If any of the referent impairments are present, these impairments must be evaluated to determine if the individual meets the listings for the impairment.

If the individual does not meet or equal the listings, physical and/or mental residual functional capacity must be evaluated to determine ability to perform work activities. The residual functional capacity assessment must take into consideration all functional limitations including those that are not related to substance abuse as well as any limitations that would be expected to remain if substance abuse were to stop.

In some instances it is difficult to distinguish between impairment of ability to perform work functions due to substance abuse from dysfunction caused by other mental and or physical impairments. If the Disability Review Team is unable to separate the effects of the substance abuse on the ability to work from work related dysfunction caused by other impairments (for example co-existing mental disorder such as personality disorder, anxiety or depression), the individual's deficits should

all be considered and evaluated as a whole.

An individual is not considered disabled if substance abuse would be a contributing factor material to the determination that the individual is disabled. If the only impairment documented is substance abuse, the individual will be determined not disabled. Therefore, it is particularly important to ensure that all relevant medical information is compiled for the disability review. Applicants who indicate they have a substance abuse problem should be asked if they have had treatment in the past or currently need treatment for any other chronic potentially disabling impairments, including those cited in listing 12.09. The local agency should obtain all available medical treatment records and arrange for a consultative exam if necessary to ensure that a complete and current file that addresses all the impairments is available for the Disability Review Team.

Local districts can use the sample consent form included in the Forms and Publications Section as Exhibit 18 to secure medical records from alcohol and drug abuse treatment and rehabilitation facilities for use in the disability determination process. The sample consent form should be reproduced on agency letterhead. Local districts which submit disability cases to the State Disability Review Team for adjudication should expressly state in the "Purpose of Disclosure" Section of the consent form that the information will be redisclosed to the New York State Department of Health, Office of Medicaid Management for determining the client's disability.

K. **Blindness**

Department Regulation Sections 360-5.12

1. **Determination of Blindness Status** - Individuals who are blind are categorically eligible for Medicaid in the SSI-related category and may qualify for special work-related disregards from their earnings. Information regarding an individual's legal blindness status may be available through the Commission for the Blind and Visually Handicapped (CBVH) if the A/R does not have verification of legal blindness.

   The agency must first obtain a signed release form from the A/R. The inquiry and signed consent to release information form can be mailed to the CBVH at the address below or can be faxed to them at (518) 486-5819. The CBVH will need the individual's name, social security number, address, and date of birth. They can provide the local district with a "Verification of Blindness" form if the individual is known to them. This form should be retained in the case record.

Office of Family and Children's Services

Commission for the Blind and Visually Handicapped
Capital View Office Park - South Building
Suite 201
52 Washington Street
Rensselaer, N.Y. 12144

If the individual has yet not been determined to be blind, the local district should assist the individual in obtaining the necessary medical evidence for submission to the CBVH. (See section 3 below.) Call (518) 474-6812 for further information.

Individuals with visual impairments that do not meet the legal definition of blind, should be referred for a disability review for evaluation under the category of disabled. (See section 4 below.)

2. **Pending Cases** - Cases which are not eligible for Medicaid under any other category and in which blindness is alleged should be pended awaiting a determination of blindness. These cases may be pended for a maximum of 45 days. The applicant should be informed of this time standard. This time limit is the maximum time period allowed and should not be used as a waiting period. Individuals who are eligible in another category should have their case opened. When blindness is subsequently established, the case should be claimed retroactively in the SSI-related blind category.

3. **Examinations** - Eye examinations can be purchased for an individual who alleges blindness and who does not have a current treating source or has a treating source who will not cooperate in completing the necessary forms. The procedures for consultative examinations are found in Section D 3.

4. **Medicaid Disability Reviews** - The local agency should submit to the Disability Review Team for a disability review the cases of individuals who have visual impairments but have been determined not to be legally blind by the CBVH. Those individuals with visual impairments shall be evaluated under Section 2.01, Special Senses and Speech of the Listing of Impairments, in Appendix I. Medical records should include an evaluation of the individual's visual fields by his/her treating physician. Form DSS-3451, "Commission for the Blind and Visually Handicapped Medical Eye Report", may be used for this purpose. (See Exhibit 17.)

L. Evaluation of Symptoms and Pain

The effect of pain and symptoms on an individual's ability to work must be considered by the Disability Review Team during the disability determination process.

1. **Presence of a Medically Determinable Impairment**

Before evaluating the effect of pain and symptoms on an individual's ability to work, it must be shown that:

a. the individual has a medically determinable physical and/or mental impairment(s) established by medically acceptable clinical or laboratory diagnostic techniques; and

b. the medically determinable impairment(s) could reasonably be expected to produce the alleged pain.

When medical findings do not substantiate any physical impairment capable of producing the alleged pain or symptoms, the possibility of a mental impairment as the basis for the pain should be considered.

In the absence of objective findings of any medically determinable physical or mental impairment, disability cannot be established regardless of the degree of pain alleged.

2. **Symptoms and Pain and the Sequential Evaluation Process**

Once a medically determinable physical and/or mental impairment is documented, symptoms and pain must be considered in determining severity and at each step of the Sequential Evaluation Process.

a. **Evaluating Severity** - To be considered severe, the individual's impairment or combination of impairments must significantly limit his/her ability to do basic work activities.

When pain is alleged and the documented impairment(s) could reasonably be expected to produce the pain, any allegations of pain-related limitations must be considered in evaluating severity. The presence of the alleged pain-related limitations may substantiate the conclusion that one or more basic work activities are affected to more than an minimal degree and that the impairment(s) is severe.

b. **Determining Meets or Equals** - A finding of disabled is made on a medical basis alone when an impairment(s) meets a listing in Appendix I or is medically the equivalent of a listed impairment. Some listings include pain as a criterion (e.g., Listings 1.02A, 1.05C and 5.07A). Under these listings, if the individual

has pain and meets the other criteria the listing would be met and no further documentation of pain would be required. In contrast, Listing 4.04 requires information about the character of the pain and documentation that the pain is of cardiac origin.

An A/R's allegation of pain or other symptoms may not be substituted for a missing or deficient sign or laboratory finding in order to determine that the impairment(s) is equivalent in severity to a listed impairment.

c. **Evaluating Residual Functional Capacity (RFC)**

(1) Before symptoms and pain can be considered in assessing RFC, a determination must be made as to whether the pain or symptoms can reasonably be expected from the particular impairment(s).

(a) When objective medical evidence supports a finding that the physical or mental impairment(s) could produce the symptoms or pain, the individual's impairment(s) and any additional limitations imposed by symptoms or pain will be considered in assessing his/her functional limitations.

(b) In some cases, the individual's allegation about the severity and persistence of pain and pain-related limitations is greater than would reasonably be expected on the basis of the objective medical evidence. In these cases, additional information concerning the pain and pain-related limitations should be obtained only if a favorable decision is not possible based on the evidence and any alleged pain-related limitations might further reduce RFC to the point where the decision might be affected.

If the additional evidence obtained from the treating source(s), the individual, and/or third parties is insufficient to make a determination, consideration should be given to the purchase of a consultative examination. Depending on the individual case, a consultative examination(s) may be obtained from a pain specialist, pain clinic, neurologist, orthopedist, and/or other specialist(s) regarding pain and its effect on the individual.

(c) When alleged symptoms and pain-related limitations are clearly out of proportion to the physical findings and a favorable determination cannot be made on the basis of the evidence, the

possibility of a mental impairment should be investigated.

(2) When it is determined that the symptoms or pain can reasonably be expected on the basis of the medical evidence, the impact of such pain on Residual Functional Capacity must be considered in terms of any additional physical or mental limitations it may impose on the individual's ability to work.

Consider information about the following:

- daily activities;
- location, duration, frequency, and intensity of symptoms or pain;
- precipitating and aggravating factors;
- the type, dosage, effectiveness and side effects of medications taken to alleviate pain or symptoms;
- treatment other than medication and any other measures used to relieve pain or other symptoms; and
- consistency of the information provided.

(a) Symptoms and pain caused by physical impairments may result in limitations in an individual's ability to perform exertional activities, such as standing, lifting, walking; non-exertional activities, such as kneeling, stooping, climbing, concentrating; or a combination of both exertional and non-exertional activities.

Mental consequences of physical findings (i.e. anxiety, depression) that occur as a natural result of a physical disease process and which are not indicative of a discreet mental illness should be considered as a non-exertional impairment under a physical RFC. The "Psychiatric Review Technique Form" (DSS-3818) and the "Mental Residual Functional Capacity Assessment Form" (DSS-3817) should not be completed.

(b) Pain or symptoms that have been documented to have no linkage to a physical body system but is present purely as a mental disorder (i.e. Somatization Disorder, Psychogenic Pain Disorder) must be evaluated based on the degree of mental impairment and any resulting limitation on the individual's activities, interests, personal habits and ability to relate to

others. The "Psychiatric Review Technique Form" (DSS-3818) may be used and where appropriate the "Mental Residual Functional Capacity Assessment Form" (DSS-3817) may be completed. (See Exhibits 5 and 6.)

Once the RFC has been established, the evaluation of the individual's ability to do past relevant work or other work in the national economy should be determined by following the procedures outlined in this manual.

3. **Pain and Medical Improvement**

Medical improvement is any decrease in the medical severity of the individual's impairment(s) since the time of the most recent favorable decision. Where medical improvement is an issue, the signs, symptoms and laboratory findings at the time of the most recent favorable decision must be compared with the current impairment(s).

A lessening of symptoms such as pain reported by the individual can be the basis for a finding that medical improvement has occurred even if there is no corresponding improvement in signs or laboratory findings. However, if such signs or laboratory findings have worsened, these would have to be considered in assessing medical improvement.

If medical improvement has occurred, it must be determined whether the medical improvement is related to the individual's ability to work and if so, whether the individual is currently able to engage in substantial gainful employment.

M. Evaluation of Children from Birth to Attainment of Age 18

1. **General**

A child is considered disabled if he/she has a medically determinable physical or mental impairment or combination of impairments that cause marked and severe functional limitations and that can be expected to cause death or that have lasted or can be expected to last for a continuous period of not less than 12 months. To be determined disabled, the impairment must meet, medically equal, or functionally equal the requirements of the medical listings of impairments found in Appendix 1 Part B. If the medical criteria in the children's listings do not apply, then the adult listings in Appendix 1 Part A may be used. Generally a child may be found disabled if the

impairment causes a marked limitation in two broad areas of function or an extreme limitation in one area.

2. **Sequential Evaluation Process**

As is the case for adults, the sequential evaluation process must be followed. (Please see the sequential evaluation flow chart for children, Policy 108.)

The steps of the sequential evaluation process for children's cases are:

- Step 1 - determining if the child is engaged in substantial gainful activity;
- Step 2 - determining if the child has a severe impairment(s); and
- Step 3 - determining if the child's impairment(s) meets, medically equals, or functionally equals a listing and meets the duration requirement.

(a) Substantial Gainful Activity - Is the child engaging in substantial gainful activity?

The basic statutory definition of disability requires an inability to engage in substantial gainful activity. The same rules for determining whether an adult is engaging in substantial gainful activity also apply to children. (Please refer to Section E.1.) Except for some older children who may be employed, most children will not be engaged in substantial gainful activity, and it will be necessary to continue with the sequential process.

If a child is engaging in substantial gainful activity, the child will be determined not disabled. If not, the sequential evaluation process will proceed to the next step.

(b) Severity of Impairment- Does the child have a "severe" impairment or combination of impairments?

The child must have a medically determinable impairment(s) that is severe. If the impairment(s) is severe, the case will be reviewed further to see if the impairment(s) meets, medically equals, or functionally equals the listings. If the child does not have a medically determinable impairment or his/her impairment(s) is a slight abnormality or combination of slight abnormalities that causes no more than minimal functional limitations, the child will be found not to have a severe impairment and will, therefore, be determined not disabled.

(c) Meeting or Equaling the Listings - Does the child have a medically determinable impairment(s) that meets, medically equals, or functionally equals a listing? An impairment(s) causes marked and severe functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or if it functionally equals the listings.

(1) Therefore, if the child has an impairment(s) that meets or medically equals the requirements of a listing or that functionally equals the listings, and that meets the duration requirement, the child will be found disabled.

(2) If the child's impairment(s) does not meet the duration requirement, or does not meet, medically equal, or functionally equal the listings, the child will be found not disabled.

3. **Considerations in Determining Disability for Children**

(a) Basic considerations. All relevant information (i.e. evidence) in the case record is considered. The evidence in the case record may include information from medical sources, such as the child's pediatrician, other physicians, psychologist, or qualified speech-language pathologist; other medical sources such as physical, occupational, and rehabilitation therapists; and non-medical sources such as the child's parents, teachers, and other people who know the child.

(1) Medical evidence

(i) General. Medical evidence of the child's impairment(s) must describe symptoms, signs, and laboratory findings. The medical evidence may include, but is not limited to, formal testing that provides information about the child's development or functioning in terms of standard deviations, percentiles, percentages of delay, or age or grade equivalents. It may also include opinions from medical sources about the nature and severity of the child's impairment.

(ii) Test scores. All of the relevant information in the case record will be considered. Consideration should not be given to any single piece of evidence in isolation. Therefore, test scores alone should not be relied on when deciding whether the child is disabled. See Section 6. (e) (3) for more information about how test scores are considered.

(iii) Medical sources. Medical sources should report their findings and observations on clinical examination and the results of any formal

testing. A medical source's report should note and resolve any material inconsistencies between formal test results, other medical findings, and the child's usual functioning. Whenever possible and appropriate, the interpretation of findings by the medical source should reflect consideration of information from the child's parents or other people who know the child, including teachers and therapists. When a medical source has accepted and relied on such information to reach a diagnosis, this information may be considered a clinical sign.

(2) Information from other people. Every child is unique, so the effects of the child's impairment(s) on his/her functioning may be very different from the effects that the same impairment(s) might have on another child. Therefore, whenever possible and appropriate, attempts will be made to get information from people who can tell what the effects of the child's impairment(s) is on his/her activities and how the child functions on a day-to-day basis. These other people may include, but are not limited to:

(i) The child's parents and other caregivers. The child's parents and other caregivers can be important sources of information because they usually see the child every day. In addition to the child's parents, other caregivers may include a childcare provider who takes care of the child while his/her parent(s) works or an adult who looks after the child in a before-or after-school program.

(ii) Early intervention and preschool programs. If the child has been identified for early intervention services (in the home or elsewhere) because of his/her impairment(s), or if the child attends a preschool program (e.g. Headstart or a public school kindergarten for children with special needs), these programs are also important sources of information about the child's functioning. Reports should be requested from the agency and individuals who provide the child with services or from the child's teachers about how the child typically functions when compared to other children the same age who do not have impairments.

(iii) School. If the child goes to school, information should be requested from his/her teachers and other school personnel about how the child is functioning there on a day-to-day basis compared to other children the same age who do not have impairments. A request should be made for any reports that the school may have that show the results of formal testing or that describe any special education instruction or services, including home-based instruction, or any accommodations provided in

a regular classroom.

(b) Factors to be considered when evaluating the effects of the child's impairment(s) on his/her functioning.

(1) General. The child's functioning must be considered when deciding whether his/her impairment(s) is "severe" and when deciding whether his/her impairment(s) functionally equals the listings. The child's functioning must also be considered when deciding whether his/her impairment(s) meets or medically equals a listing if the listing being considered includes functioning among its criteria.

(2) Factors to be considered when evaluating the child's functioning. The child's limitations in functioning must result from his/her medically determinable impairment(s). The information obtained from the child's medical and non-medical sources can help in understanding how the child's impairment(s) affects his/her functioning. Any factors that are relevant to how the child functions will be considered when evaluating the child's impairment or combination of impairments. For example, the child's symptoms (such as pain, fatigue, decreased energy, or anxiety) may limit his/her functioning. Some other factors that may be considered when evaluating the child's functioning are explained in paragraphs (b) (3) - (b) (9) of this section.

(3) How the child's functioning compares to the functioning of children the same age who do not have impairments.

(i) General. When the child's functioning is evaluated, consider whether the child does the things that other children the same age typically do or whether the child has limitations and restrictions because of his/her medically determinable impairment(s). Also, consider how well the child does the activities and how much help he/she needs from family, teachers and others. Information about what the child can and cannot do, and how the child functions on a day to day basis at home, at school and in the community, allows a comparison of the child's activities to the activities of children the same age who do not have impairments.

(ii) How to consider reports of the child's functioning. When considering the evidence in the child's case record about the quality of his/her activities, consider the standards used by the person who gave the information. Also, consider the characteristics of the group to whom

the child is being compared. For example, if the way the child does his/her class work is compared to other children in a special education class, consider that the child is being compared to children who do have impairments.

(4) Combined effects of multiple impairments. If the child has more than one impairment, consider whether the child has a "severe" impairment or an impairment that meets, medically equals, or functionally equals the listings by looking at each of the child's impairments separately. If each separate impairment does not meet or equal the listings, consider comprehensively the combined effects of all the child's impairments on his/her day to day functioning instead of considering the limitations resulting from each impairment separately. (See Sec. 6. (c) for more information on how to consider the interactive and cumulative effects of the child's impairments on functioning.)

(5) How well can the child initiate, sustain, and complete his/her activities, including the amount of help or adaptations he/she needs, and the effects of structured or supportive settings.

(i) Initiating, sustaining, and completing activities. Consider how effectively the child functions by examining how independently the child is able to initiate, sustain, and complete his/her activities despite his/her impairment(s) compared to other children the same age who do not have impairments. Consider:

(A) The child's range of activities;
(B) The child's ability to do them independently, including any prompting that the child may need to begin, carry through, and complete his/her activities;
(C) The pace at which the child does his/her activities;
(D) How much effort the child needs to make in order to do his/her activities; and
(E) How long the child is able to sustain his/her activities.

(ii) Extra help. Consider how independently the child is able to function compared to other children the same age who do not have impairments. Consider whether the child needs help from other people, or whether the child needs special equipment, devices, or medications to perform his/her day-to-day activities. For example, consider how much supervision the child needs to keep from hurting

him/herself, how much help the child needs every day to get dressed or, in the case of an infant, how long it takes the parents or other caregivers to feed the infant. Children are often able to do things and complete tasks when given help, but may not be able to do these same things by themselves. Therefore, consider how much extra help the child needs, what special equipment or devices the child uses, and the medication the child takes that enable him/her to participate in activities like other children the same age who do not have impairments.

(iii) Adaptations. Consider the nature and extent of any adaptations used by the child to enable him/her to function. Such adaptations may include assistive devices or appliances. Some adaptations may enable the child to function normally or almost normally (e.g., eyeglasses). Others may increase the child's functioning, even though the child may still have functional limitations (e.g., ankle-foot orthoses, hand or foot splints, and specially adapted or custom-made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting and dressing). When evaluating the functioning of a child with an adaptation, consider the degree to which the adaptation enables the child to function compared to other children the same age who do not have impairments. Consider the child's ability to use the adaptation effectively on a sustained basis and any functional limitations that nevertheless persist.

(iv) Structured or supportive settings.

(A) If the child has a serious impairment(s), the child may spend some or all of his/her time in a structured or supportive setting, beyond what a child who does not have an impairment typically needs.

(B) A structured or supportive setting may be the child's own home in which family members or other people (e.g., visiting nurses or home health workers) make adjustments to accommodate the child's impairment(s). A structured or supportive setting may also be the child's classroom at school, whether it is a regular classroom in which the child is accommodated or a special classroom. It may also be a residential facility or school where the child lives for a period of time.

(C) A structured or supportive setting may minimize signs and

symptoms of the child's impairment(s) and help to improve his/her functioning while the child is in it, but the child's signs, symptoms, and functional limitations may worsen outside this type of setting. Therefore, consider the child's need for a structured setting and the degree of limitation in functioning the child has or would have outside the structured setting. Even if the child is able to function adequately in the structured or supportive setting, consider how the child functions in other settings and whether the child would continue to function at an adequate level without the structured or supportive setting.

(D) If the child has a chronic impairment(s), the child may have his/her activities structured in such a way as to minimize stress and reduce the symptoms or signs of the impairment(s). The child may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, although at a lesser level of severity. Consider whether the child is more limited in functioning than his/her symptoms and signs would indicate.

(E) Therefore, if the child's symptoms or signs are controlled or reduced in a structured setting, consider how well the child is functioning in the setting and the nature of the setting in which the child is functioning (e.g. home or a special class). Consider the amount of help the child needs from his/her parents, teachers or others to function as well as he/she does; adjustments the child makes to structure his/her environment; and how the child would function without the structured or supportive setting.

(6) Unusual settings. Children may function differently in unfamiliar or one-to-one settings than they do in their usual settings at home, at school, in childcare or in the community. The child may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. Therefore, apply the guidance in paragraph (b) (5) of this section when considering how the child functions in an unusual or one-to-one situation. Look at the child's performance in a special situation and at the child's typical day-to-day functioning in routine situations. Inferences should not be drawn about the child's functioning in other situations based only on how the child functions in a one-to-one, new, or unusual situation.

(7) Early intervention and school programs.

(i) General. If the child is very young and has been identified for early intervention services, or if the child attends school (including preschool), the records of people who know the child or who have examined the child are important sources of information about the child's impairment(s) and its effects on the child's functioning. Records from physicians, teachers and school psychologists, or physical, occupational, or speech-language therapists are examples of what information may be considered. If the child receives early intervention services or goes to school or preschool, consider this information when it is relevant and available.

(ii) School evidence. If the child goes to school or preschool, try to obtain information from the child's teacher(s) about his/her performance in activities throughout the school day. Consider all of the evidence received from the child's school, including teacher questionnaires, teacher checklists, group achievement testing, and report cards.

(iii) Early intervention and special education programs. If the child has had a comprehensive assessment for early intervention services or special education services, consider information used by the assessment team to make its recommendations. Consider the information in the child's Individualized Family Service Plan, his/her Individualized Education Program, or his/her plan for transition services to help understand the child's functioning. Examine the goals and objectives of the child's plan or program as further indicators of the child's functioning, as well as statements regarding related services, supplementary aids, program modifications, and other accommodations recommended to help the child function together with the other relevant information in the child's case record.

(iv) Special education or accommodations. Consider the fact that the child attends school, that the child may be placed in a special education setting, or that the child receives special accommodations because of his/her impairments along with the other information in the case record. The fact that the child attends school does not mean that the child is not disabled. The fact that the child does or does not receive special education services does not, in itself, establish the child's actual limitations or abilities. Children are placed in special education settings, or are included in regular classrooms (with or without accommodation), for many reasons that may or may not be related to the level of their impairments. For example, the child may receive

one-to-one assistance from an aide throughout the day in a regular classroom, or be placed in a special classroom. Consider the circumstances of the child's school attendance, such as his/her ability to function in a regular classroom or preschool setting with children the same age who do not have impairments. Similarly, consider that good performance in a special education setting does not mean that the child is functioning at the same level as other children the same age who do not have impairments.

(v) Attendance and participation. Also, consider factors affecting the child's ability to participate in his/her education program. The child may be unable to participate on a regular basis because of the chronic or episodic nature of his/her impairment(s) or his/her need for therapy or treatment. If a child has more than one impairment, consider whether the effects of the child's impairments taken together make the child unable to participate on a regular basis. Consider how the child's temporary removal or absence from the program affects his/her ability to function compared to other children the same age who do not have impairments.

(8) The impact of chronic illness and limitations that interfere with the child's activities over time. If the child has a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission (improvement), consider the frequency and severity of the episodes of exacerbation as factors that may be limiting the child's functioning. The child's level of functioning may vary considerably over time. Proper evaluation of the child's ability to function in any domain requires taking into account any variations in the child's level of functioning to determine the impact of the child's chronic illness on his/her ability to function over time. If the child requires frequent treatment, consider it as explained in paragraph (b) (9) (ii) of this section.

(9) The effects of treatment (including medications and other treatment). Evaluation of the effects of the child's treatment is done to determine its effect on the child's functioning in his/her particular case.

(i) Effects of medication. Consider the effects of medication on the child's symptoms, signs, laboratory findings, and functioning. Although medications may control the most obvious manifestations of the child's impairment(s), they may or may not affect the functional limitations imposed by the child's impairment(s). If the child's

symptoms or signs are reduced by medications, consider:

(A) Any of the child's functional limitations that may nevertheless persist, even if there is improvement from the medications;

(B) Whether the child's medications create any side effects that cause or contribute to the child's functional limitations;

(C) The frequency of the child's need for medication;

(D) Change in the child's medication or the way the child's medication is prescribed; and

(E) Any evidence over time of how medication helps or does not help the child to function compared to other children the same age who do not have impairments.

(ii) Other treatment. Consider also the level and frequency of treatment other than medications that the child gets for his/her impairment(s). The child may need frequent and ongoing therapy from one or more medical sources to maintain or improve his/her functional status. (Examples of therapy include occupational, physical, or speech and language therapy, nursing or home health services, psychotherapy, or psychosocial counseling.) Frequent therapy, although intended to improve the child's functioning in some ways, may also interfere with the child's functioning in other ways. Therefore, consider the frequency of any therapy the child must have and how long the child has received or will need it. Also, consider whether the therapy interferes with the child's participation in activities typical of other children the same age who do not have impairments, such as attending school or classes and socializing with peers. If the child's activities at school or at home are frequently interrupted for therapy, consider whether these interruptions interfere with the child's functioning. Also, consider the length and frequency of the child's hospitalization.

(iii) Treatment and intervention, in general. With treatment or intervention, the child may not only have his/her symptoms or signs reduced, but may also maintain, return to, or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations.

4. **Age as a Factor in the Sequential Evaluation Process for Children**

(a) Age may or may not be a factor in determining whether a child's impairment(s) meets or medically equals a listing. This depends on the listing used for comparison. Age, however, is an important factor used in deciding whether a child's impairment(s) is severe and whether it functionally equals the listings. Except in the case of certain premature infants, as described in paragraph (b) of this section, age means chronological age.

(1) When determining whether a child has an impairment or combination of impairments that is severe, the child's functioning is compared to that of other children the same age who do not have impairments.

(2) When determining whether a child's impairment(s) meets a listing, the child's age may or may not need to be considered. The listings describe impairments that are considered to be of such significance that they are presumed to cause marked and severe functional limitations.

(i) If the listing appropriate for evaluating the child's impairment is divided into specific age categories, the child's impairment will be evaluated according to his/her age when it is determined that the child's impairment meets that listing.

(ii) If the listing appropriate for evaluating the child's impairment does not include specific age categories, a decision as to whether the child's impairment meets the listing will be made without giving consideration to age.

(3) When comparing an unlisted impairment or a combination of impairments with the listings to determine whether the impairment(s) medically equals the severity of a listing, consideration of the child's age will depend on the listing used for comparison. The same principles for considering age will be used as in paragraphs(a) (2) (i) and (a) (2) (ii) of this section that is, we will consider the child's age only if we are comparing the child's impairment(s) to a listing that includes specific age categories.

(4) Consideration will also be given to a child's age and whether it affects his/her ability to be tested. If the child's impairment is not amenable to formal testing because of his/her age, all information in the child's case record must be considered in determining whether the child is disabled. In

order to help evaluate the existence and severity of the child's impairment(s), consideration will be given to other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

(b) Correcting chronological age of premature infants. Chronological age (that is, a child's age based on birth date) is generally used when deciding whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if a child was born prematurely, the child may be considered younger than his/her chronological age. When evaluating the development or linear growth of a child born prematurely, a "corrected" chronological age may be used; that is, the chronological age adjusted by a period of gestational prematurity. An infant born at less than 37 weeks' gestation is considered to be born prematurely.

(1) A corrected chronological age is applied in the following situations:

(i) When evaluating developmental delay in premature children until the child's prematurity is no longer a relevant factor; generally no later than about chronological age 2 (see paragraph (b) (2) of this section);

(ii) When evaluating an impairment of linear growth, such as under the listings in Sec. 100.00 in Appendix 1, Subpart B, until the child is 12 months old. In this situation, refer to the neonatal growth charts which have been developed to evaluate growth in premature infants (see paragraph (b) (2) of this section).

(2) A corrected chronological age is computed as follows:

(i) If the child has not attained age 1, the child's chronological age will be corrected. The corrected chronological age is computed by subtracting the number of weeks of prematurity (i.e., the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from the child's chronological age. The result is the child's corrected chronological age.

(ii) If the child is over age 1, has a developmental delay, and prematurity is still a relevant factor in the case (generally, no later than about chronological age 2), a decision whether to correct the child's chronological age must be made. The decision should be based on judgement and all the facts in the child's case. If a decision is made to correct the child's chronological

age, it may be corrected by subtracting the full number of weeks of prematurity or a lesser number of weeks. A decision may also be made not to correct the child's chronological age if it can be determined from the evidence that that the child's developmental delay is the result of the child's medically determinable impairment(s) and is not attributable to the child's prematurity.

(3) Notwithstanding the provisions in paragraph (b) (1) of this section, a corrected chronological age will not be computed if the medical evidence shows that the child's treating source or other medical source has already taken the child's prematurity into consideration in his or her assessment of the child's development. Also, a corrected chronological age will not be computed when the child is found disabled using the examples of functional equivalence based on low birth weight in Section 6. (m) (7) and (8).

5. **Medical Equivalence**

(a) How medical equivalence is determined. A decision will be made that the child's impairment is medically equivalent to a listed impairment in Appendix I if the medical findings are at least equal in severity and duration to the listed findings. The signs, symptoms and laboratory findings related to the child's impairment(s), as found in the medical evidence, are compared with the corresponding medical criteria shown for any listed impairment. When making a finding of medical equivalence, all relevant evidence in the case record should be considered. Medical equivalence can be found in two ways:

(1) If the child has a listed impairment but does not exhibit one or more of the medical findings specified in the listing, or exhibits all of the medical findings but one or more of the findings is not as severe as specified in the listing, the child may be found to equal the listing if there are other medical findings related to the impairment that are at least of equal medical significance.

(2) If the child has an unlisted impairment or a combination of impairments no one of which meets or equals a listing, the medical findings are compared to medical findings for a closely related impairment. If the medical findings are at least of equal significance to a closely analogous listed impairment, the child may be found to equal the listings.

(b) If the impairment meets or medically equals the severity of a listed impairment, and also meets the duration requirement, the impairment will be found to cause

marked and severe limitations, and the child will be determined disabled. (Note: If the medical criteria in the children's criteria do not apply, the adult medical listings should be used.)

(c) If the impairment does not meet or medically equal the severity of a listed impairment, proceed to determine whether the impairment functionally equals the severity of a listed impairment.

6. **Functional Equivalence for Children**

(a) General. If the child has a severe impairment or combination of impairments that does not meet or medically equal any listing, a decision must be made as to whether the impairment(s) results in limitations that functionally equal the listings. "Functionally equaling the listings," means that the child's impairment(s) is of listing-level severity; i.e., it must result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain, as explained in this section. An assessment of the functional limitations caused by the child's impairment(s) must be done; i.e. what the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of his/her impairment(s). When making a finding regarding functional equivalence, assess the interactive and cumulative effects of all of the impairments for which there is evidence, including any impairments the child has that are not "severe." When assessing the child's functional equivalence, consider all relevant factors including, but not limited to:

(1) How well the child can initiate and sustain activities, how much extra help the child needs, and the effects of structured or supportive settings (see Sect. 3 (b) (5));

(2) How the child functions in school (see Sect. 3 (b) (7)); and

(3) The effects of the child's medication or other treatment (see Sect. 3 (b) (9).

(b) How the child's functioning is considered. Look at the information contained in the child's case record about how the child's functioning is affected during all of his/her activities when deciding whether the child's impairment or combination of impairments functionally equals the listings. The child's activities are everything he/she does at home, at school, and in his/her community. Review how appropriately, effectively, and independently the child performs his/her activities compared to the performance of other children the same age who do not have

impairments.

(1) How the child functions in his/her activities will be considered in terms of six domains. These domains are broad areas of functioning intended to capture all of what a child can or cannot do. In paragraphs (g) through (l), each domain is described in general terms. For most of the domains, examples are also provided of activities that illustrate the typical functioning of children in different age groups. For all of the domains, examples are provided of limitations within the domains. However, it is recognized that there is a range of development and functioning, and that not all children within an age category are expected to be able to do all of the activities in the examples of typical functioning. It is also recognized that limitations of any of the activities in the examples do not necessarily mean that a child has a "marked" or "extreme" limitation as defined in paragraph (e) of this section. The domains that are used are:

(i) Acquiring and using information;
(ii) Attending and completing tasks;
(iii) Interacting and relating with others;
(iv) Moving about and manipulating objects;
(v) Caring for oneself; and
(vi) Health and physical well-being.

(2) When evaluating the child's ability to function in each domain, ask for and consider information that will help answer the following questions about whether the child's impairment(s) affects his/her functioning and whether the child's activities are typical of other children the same age who do not have impairments.

(i) What activities is the child able to perform?
(ii) What activities is the child not able to perform?
(iii) Which of the child's activities are limited or restricted compared to other children the same age who do not have impairments?
(iv) Where does the child have difficulty with his/her activities - at home, in childcare, at school, or in the community?
(v) Does the child have difficulty independently initiating, sustaining, or completing activities?
(vi) What kind of help does the child need to do his/her activities, how much help does the child need, and how often does he/she need it?

(3) Try to get information from sources who can tell about the effects of the child's impairment(s) and how the child functions. Try to obtain information from the child's treating and other medical sources who have seen the child and can give their medical finding and opinions about the child's limitations and restrictions. Also, obtain information from the child's parents and teachers and others who see the child often and can describe the child's functioning at home, in childcare, at school, and in the community.

(c) The interactive and cumulative effects of an impairment or multiple impairments. When evaluating the child's functioning and deciding which domains may be affected by the child's impairment(s), consider first the child's activities and his/her limitations and restrictions. Any given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And, any given impairment may have effects in more than one domain; therefore, evaluate the limitations from the child's impairment(s) in any affected domain(s).

(d) How to decide if the child's impairment(s) functionally equals the listings. The child's impairment(s) will be found to functionally equal the listings if it is of listing level severity. The child's impairment is of listing-level severity if the child has "marked" limitations in two of the domains in paragraph (b) (1) of this section, or an "extreme" limitation in one domain. The child's functioning should not be compared to the requirements of any specific listing. The terms "marked" and "extreme" are explained in paragraph (e) of this section. An explanation of how to use the domains is found in paragraph (f) of this section, and a description of each domain can be found in paragraphs (g) - (l). The duration requirement must also be met.

(e) How "marked" and "extreme" limitations are defined.

(1) General.

(i) When deciding whether the child has a "marked or an "extreme" limitation, consider the functional limitations resulting from all of the child's impairments, including their interactive and cumulative effects. Consider all of the relevant information in the child's case record that will help in determining the child's functioning, including the child's signs, symptoms, and laboratory findings, the descriptions provided about the child's functioning from his/her parents, teachers, and other people who know the child, and the relevant factors explained in the previous sections.

(ii) The medical evidence may include formal testing that provides information about the child's development or functioning in terms of percentiles, percentages of delay, or age or grade equivalents. Standard scores (e.g., percentiles) can be converted to standard deviations. When such scores are available, consider them together with the information obtained about the child's functioning to determine whether the child has a "marked" or "extreme" limitation in a domain.

(2) Marked limitation.

(i) The child will be found to have a "marked" limitation in a domain when his/her impairment(s) interferes seriously with his/her ability to initiate, sustain, or complete activities. The child's day-to-day functioning may be seriously limited when his/her impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Marked" limitation also means a limitation that is "more than moderate" but "less than extreme." It is the equivalent of the functioning that would be expected to be found on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.

(ii) If the child has not attained age 3, it will generally be found that the child has a "marked" limitation if he/she is functioning at a level that is more than one-half but not more than two-thirds of his/her chronological age when there are no standard scores from standardized tests in the child's case record.

(iii) A child of any age (birth to the attainment of age 18) will be found to have a "marked" limitation when the child has a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and when the child's day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e) (4) of this section.)

(iv) For the sixth domain of functioning, "Health and physical well-being", the child may be considered to have a "marked" limitation if he/she is frequently ill because of his/her impairment(s) or has frequent

exacerbations of his/her impairment(s) that result in significant, documented symptoms or signs. For the purposes of this domain, "frequent means that the child has episodes of illness or exacerbations that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. A "marked" limitation may also be found if the child has episodes that occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

(3) Extreme limitation.

(i) The child will be found to have an "extreme" limitation in a domain when the child's impairment(s) interferes very seriously with his/her ability to independently initiate, sustain, or complete activities. The child's day-to-day functioning may be very seriously limited when his/her impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Extreme" limitation also means a limitation that is "more than marked" and is the rating given to the worst limitations. However, "extreme limitation" does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning expected to be found on standardized testing with scores that are at least three standard deviations below the mean.

(ii) If the child has not attained age 3, it will generally be found that the child has an "extreme" limitation if he/she is functioning at a level that is one-half of his/her chronological age or less when there are no standard scores from standardized tests in the child's case record.

(iii) A child of any age (birth to the attainment of age 18) will be found to have an "extreme" limitation when he/she has a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and when the child's day-to-day functioning in domain-related activities is consistent with that score. (See paragraph (e) (4) of this section.)

(iv) For the sixth domain of functioning, "Health and physical well- being", the child may be considered to have an "extreme" limitation if he/she is frequently ill because of his/her impairment(s) or has frequent exacerbations of his/her impairment(s) that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a "marked" limitation in paragraph (e) (2) (iv) of this section. However, if the child has episodes of illness or exacerbations of his/her impairment(s) that would be rated as "extreme" under this definition, the child's impairment(s) should meet or medically equal the requirements of a listing in most cases.

(4) How test scores are considered.

(i) As indicated in Sec. (3) (a) (1) (ii), any test scores alone should not be relied on. No single piece of information taken in isolation can establish whether a child has a "marked" or an "extreme" limitation in a domain.

(ii) The child's test scores should be considered together with the other information obtained about the child's functioning, including reports of classroom performance and the observation of school personnel and others.

(A) It may be found that the child has a "marked" or "extreme" limitation when he/she has a test score that is slightly higher than the level provided in paragraph (e) (2) or (e) (3) of this section, if other information in the child's case record shows that his/her functioning in day-to-day activities is seriously or very seriously limited because of his/her impairment(s). For example, the child may have IQ scores above the level in paragraph (e) (2), but other evidence shows that the child's impairment(s) cause him/her to function in school, home, and community far below his/her expected level of functioning based on this score.

(B) On the other hand, it may be found that the child does not have a "marked" or "extreme" limitation, even if the child's test scores are at the level provided in paragraph (e) (2) or (e) (3) of this section, if other information in the child's case record shows that his/her functioning in day-to-day activities is not seriously or very seriously

limited by his/her impairment(s). For example, the child may have a valid IQ score below the level in paragraph (e) (2), but other evidence shows that the child has learned to drive a car, shop independently, and read books near his/her expected grade level.

(iii) If there is a material inconsistency between the child's test scores and other information in the child's case record, try to resolve it. The interpretation of the test is primarily the responsibility of the psychologist or other professional who administered the test. But it is also the reviewer's responsibility to ensure that the evidence in the child's case record is complete and consistent or that any material inconsistencies have been resolved. Therefore, the following guidelines will be used to resolve concerns about the child's test scores:

(A) The inconsistencies may be able to be resolved with the information on hand. It may be necessary to obtain additional information; e.g., by recontact with the child's medical source(s), by recontact with a medical source who provided a consultative exam, or by questioning individuals familiar with the child's day-to-day functioning.

(B) Generally, a test score should not be relied on as a measurement of the child's functioning within a domain when the information obtained about the child's functioning is the kind of information typically used by medical professionals to determine that the test results are not the best measure of the child's day-to-day functioning. When test scores are not relied on, an explanation of the reasons for doing so should be documented on the "Disability Review Team Certificate" (LDSS 639).

(f) How domains are used to help evaluate the child's functioning.

(1) When considering whether the child has a "marked" or "extreme" limitation in any domain, examine all the information in the child's case record about how the child's functioning is limited because of his/her impairment(s). Compare the child's functioning to the typical functioning of children the same age who do not have impairments.

(2) The general descriptions of each domain in paragraphs (g) - (l) will help in deciding whether the child has limitations in any given domain and whether these limitations are "marked" or "extreme."

(3) The domain descriptions also include examples of some activities typical of

children in each age group and some functional limitations that may be considered. These examples also help in deciding whether the child has limitations in a domain because of his/her impairment(s). The examples are not all-inclusive, and developing evidence about each specific example is not required. When the child has limitations in a given activity or activities in the examples, a decision may or may not be made that the child has a "marked" or "extreme" limitation in that domain. Consider the activities in which the child is limited because of his/her impairment(s) and the extent of the child's limitations under the rules in paragraph (e) of this section.

(g) *Acquiring and using information.* In this domain, consideration is given to how well the child acquires or learns information, and how well the child uses the information he/she has learned.

(1) General.

(i) Learning and thinking begin at birth. A child learns as he/she explores the world through sight, sound, taste, touch, and smell. As a child plays, he/she acquires concepts and learns that people, things, and activities have names. This lets the child understand symbols, which prepares him/her to use language for learning. Using the concepts and symbols acquired through play and learning experiences, the child should be able to learn to read, write, do arithmetic, and understand and use new information.

(ii) Thinking is the application or use of information the child has learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When a child thinks in pictures, he/she may solve a problem by watching and imitating what another person does. When a child thinks in words, he/she may solve a problem by using language to talk his/her way through it. A child must also use language to think about the world and to understand others and express him/herself; e.g., to follow directions, ask for information, or explain something.

(2) Age group descriptors

(i) Newborns and young infants (birth to attainment of age 1). At this age, a child should show interest in and explore his/her environment. At first, a child's actions are random; for example, when the child accidentally touches the mobile over his/her crib. Eventually, the child's actions should become deliberate and purposeful, such as when he/she shakes noisemaking toys like a bell or rattle. The child should begin to recognize, and then anticipate,

routine situations and events, such as when he/she grins at the sight of his/her stroller. The child should also recognize and gradually attach meaning to everyday sounds, such as when he/she hears the telephone or his/her name. Eventually, the child should recognize and respond to familiar words, including family names and what his/her favorite toys and activities are called.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child is learning about the world around him/her. When the child plays, he/she should learn how objects go together in different ways. The child should learn that by pretending, his/her actions can represent real things. This helps the child understand that words represent things, and that words are simply symbols or names for toys, people, places, and activities. The child should refer to him/herself and the things around him/her by pointing and eventually naming. The child should form concepts and solve simple problems through purposeful experimentation (e.g., taking toys apart), imitation, constructive play (e.g., building with blocks), and pretend play activities. The child should begin to respond to increasingly complex instructions and questions, and to produce an increasing number of words and grammatically correct simple sentences and questions.

(iii) Preschool children (age 3 to attainment of age 6). When the child is old enough to go to preschool or kindergarten, the child should begin to learn and use the skills that will help him/her to read and write and do arithmetic when he/she is older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what he/she means, and tell stories allows the child to acquire and share knowledge and experience of the world around him/her. All of these are called "readiness skills," and the child should have them by the time he/she begins first grade.

(iv) School-age children (age 6 to attainment of age 12). When the child is old enough to go to elementary and middle school, he/she should be able to learn to read, write, do math, and discuss history and science. The child will need to use these skills in academic situations to demonstrate what he/she has learned; e.g., by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. The child will also need to use these skills in daily living situations at home and in the

community (e.g., reading street signs, telling time, and making change). The child should be able to use increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing his/her own ideas, and by understanding and responding to the opinions of others.

(v) Adolescents (age 12 to attainment of age 18). In middle and high school, the child should continue to demonstrate what he/she has learned in academic assignments (e.g., composition, classroom discussion, and laboratory experiments). The child should also be able to use what he/she has learned in daily living situations without assistance (e.g., going to the store, using the library, and using public transportation). The child should be able to comprehend and express both simple and complex ideas, using increasingly complex language (vocabulary and grammar) in learning and daily living situations (e.g. to obtain and convey information and ideas). The child should also learn to apply these skills in practical ways that will help him/her enter the workplace after he/she finishes school (e.g., carrying out instructions, preparing a job application, or being interviewed by a potential employer).

(3) Examples of limited functioning in acquiring and using information. The following examples describe some limitations found in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitation must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child does not demonstrate understanding of words about space, size, or time; e.g., in/under, big/little, morning/night.
(ii) The child cannot rhyme words or the sounds in words.
(iii) The child has difficulty recalling important things he/she has learned in school yesterday.
(iv) The child has difficulty solving mathematics questions or computing arithmetic answers.
(v) The child talks only in short, simple sentences and has difficulty explaining what he/she means.

(h) *Attending and completing tasks.* In this domain, consideration is given to how well the child is able to focus and maintain attention, and how well the child begins, carries through, and finishes his/her activities, including the pace at which he/she performs activities and the ease with which he/she changes them.

(1) General.

(i) Attention involves regulating levels of alertness and initiating and maintaining concentration. It involves the ability to filter out distractions and to remain focused on an activity or task at a consistent level of performance. This means focusing long enough to initiate and complete an activity or task, and changing focus once it is completed. It also means that if the child loses or changes focus in the middle of a task, he/she is able to return to the task without other people having to remind him/her frequently to finish it.

(ii) Adequate attention is needed to maintain physical and mental effort and concentration on an activity or task. Adequate attention permits the child to think and reflect before starting or deciding to stop an activity. In other words, the child is able to look ahead and predict the possible outcomes of his/her actions before acting. Focusing attention allows the child to attempt tasks at an appropriate pace. It also helps the child determine the time needed to finish a task within an appropriate timeframe.

(2) Age group descriptors.

(i) Newborns and young infants (birth to attainment of age 1). The child should begin at birth to show sensitivity to his/her environment by responding to various stimuli (e.g., light, touch, temperature, movement). Very soon, the child should be able to fix his/her gaze on a human face. The child should stop his/her activity when he/she hears voices or sounds. Next, the child should begin to attend to and follow various moving objects with his/her gaze, including people and toys. The child should be listening to his/her family's conversations for longer and longer periods of time. Eventually, as the child is able to move around and explore his/her environment, he/she should begin to play with people and toys for longer periods of time. The child will still want to change activities frequently, but his/her interest in continuing interaction or a game should gradually expand.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child should be able to attend to things that interest him/her and have adequate

attention to complete some tasks by him/herself. As a toddler, the child should demonstrate sustained attention, such as when looking at picture books, listening to stories, or building with blocks, and when helping to put on his/her clothes.

(iii) Preschool children (age 3 to attainment of age 6). As a preschooler, the child should be able to pay attention when he/she is spoken to directly, sustain attention to play and learning activities, and concentrate on activities like putting puzzles together or completing art projects. The child should also be able to focus long enough to do more things by him/herself, such as getting his/her clothes together, dressing him/herself, feeding him/herself, or putting away his/her toys. The child should be able to wait his/her turn or to change his/her activity when a caregiver or teacher says it is time to do something else.

(iv) School-age children (age 6 to attainment of age 12). When the child is of school age, he/she should be able to focus his/her attention in a variety of situations in order to follow directions, remember and organize his/her school materials, and complete classroom and homework assignments. He/she should be able to concentrate on details and not make careless mistakes in his/her work (beyond what would be expected in other children the same age who do not have impairments). The child should be able to change his/her activities or routines without distracting him/herself or others, and stay on task and in place when appropriate. The child should be able to sustain his/her attention well enough to participate in group sports, read by him/herself, and complete family chores. The child should also be able to complete a transition task (e.g., be ready for the school bus, change clothes after gym, change classrooms) without extra reminders and accommodation.

(v) Adolescents (age 12 to attainment of age 18). In the child's later years of school, he/she should be able to pay attention to increasingly longer presentations and discussions, maintain his/her concentration while reading textbooks, and independently plan and complete long-range academic projects. The child should also be able to organize his/her materials and to plan his/her time in order to complete school tasks and assignments. In anticipation of entering the workplace, the child should be able to maintain his/her attention on a task for extended periods of time, and not be unduly distracted by his/her peers or unduly distracting to them in a school or work setting.

(3) Examples of limited functioning in attending and completing tasks. The following examples describe some limitations that may be considered in this domain. The

child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record will be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child is easily startled, distracted, or overreactive to sounds, sights, movements, or touch.
(ii) The child is slow to focus on, or fails to complete activities of interest to him/her, e.g., games or art projects.
(iii) The child repeatedly becomes sidetracked from his/her activities or he/she frequently interrupts others.
(iv) The child is easily frustrated and gives up on tasks, including ones that he/she is capable of completing.
(v) The child requires extra supervision to keep him/her engaged in an activity.

(i) *Interacting and relating with others.* In this domain, consideration is given to how well the child initiates and sustains emotional connections with others, develops and uses the language of his/her community, cooperates with others, complies with the rules, responds to criticism, and respects and takes care of the possessions of others.

(1) General.

(i) Interacting means initiating and responding to exchanges with other people, for practical or social purposes. A child interacts with others by using facial expressions, gestures, actions, or words. The child may interact with another person only once, as when asking a stranger for directions, or many times, as when describing his/her day at school to his/her parents. The child may interact with people one-at-a-time, as when he/she is listening to another student in the hallway at school, or in groups, as when he/she plays with others.

(ii) Relating to other people means forming intimate relationships with family members and with friends who are the child's age, and sustaining them over time. The child may relate to individuals, such as his/her siblings, parents or best friend, or to groups, such as other children in childcare, his/her friends in school, teammates in sports activities, or people in his/her

neighborhood.

(iii) Interacting and relating requires the child to respond appropriately to a variety of emotional and behavioral cues. The child may be able to speak intelligibly and fluently so that others can understand him/her; participate in verbal turn-taking and nonverbal exchanges; consider others' feelings and points of view; follow social rules for interaction and conversation; and respond to others appropriately and meaningfully.

(iv) The child's activities at home, school or in his/her community may involve playing, learning, and working cooperatively with other children, one-at-a-time or in groups; joining voluntarily in activities with the other children in his/her school or community; and responding to persons (e.g., a parent, teacher, bus driver, coach, or employer).

(2) Age group descriptors.

(i) Newborns and young infants (birth to the attainment of age 1). The child should begin to form intimate relationships at birth by gradually responding visually and vocally to his/her caregiver(s), through mutual gaze and vocal exchanges, and by physically molding his/her body to the caregiver's while being held. The child should eventually initiate give-and-take games (such as pat-a-cake, peek-a-boo) with his/her caregivers, and begin to affect others through his/her own purposeful behavior (e.g., gestures and vocalizations). The child should be able to respond to a variety of emotions (e.g., facial expressions and vocal tone changes). The child should begin to develop speech by using vowel sounds and later consonants, first alone, and then in babbling.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child is dependent upon his/her caregivers, but should begin to separate from them. The child should be able to express emotions and respond to the feelings of others. The child should begin initiating and maintaining interactions with adults, but also show interest in, then play alongside, and eventually interact with other children his/her age. The child should be able to spontaneously communicate his/her wishes or needs, first by using gestures, and eventually by speaking words clearly enough that people who know him/her can understand what he/she says most of the time.

(iii) Preschool children (age 3 to attainment of age 6). At this age, the child should be able to socialize with children as well as adults. The child should begin

to prefer playmates his/her own age and start to develop friendships with children who are the same age. The child should be able to use words instead of actions to express him/herself, and also be better able to share, show affection, and offer to help. The child should be able to relate to caregivers with increasing independence, choose his/her own friends, and play cooperatively with other children, one-at-a-time or in a group, without continual adult supervision. The child should be able to initiate and participate in conversations, using increasingly complex vocabulary and grammar, and speak clearly enough that both familiar and unfamiliar listeners can understand what he/she says most of the time.

(iv) School-age children (age 6 to attainment of age 12). When the child enters school, he/she should be able to develop more lasting friendships with children who are the same age. The child should begin to understand how to work in groups to create projects and solve problems. He/she should have an increasing ability to understand another's point of view and to tolerate differences. The child should be able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners readily understand.

(v) Adolescents (age 12 to attainment of age 18). By the time the child reaches adolescence, he/she should be able to initiate and develop friendships with children who are the same age and to relate appropriately to other children and adults, both individually and in groups. The child should begin to be able to solve conflicts between him/herself and peers or family members or adults outside his/her family. The child should recognize that there are different social rules for him/her and for his/her friends and for acquaintances or adults. The child should be able to intelligibly express his/her feelings, ask for assistance in getting his/her needs met, seek information, describe events, and tell stories, in all kinds of environments (e.g., home, classroom, sports, extra-curricular activities, or part-time job), and with all types of people (e.g., parents, siblings, friends, classmates, teachers, employers, and strangers).

(3) Examples of limited functioning in interacting and relating with others. The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or an "extreme" limitation. Whether an example applies in the child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations

must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child does not reach out to be picked up and held by his/her caregiver.
(ii) The child has no close friends, or his/her friends are all older or younger than him/her.
(iii) The child avoids or withdraws from people he/she knows, or he/she is overly anxious or fearful of meeting new people or trying new experiences.
(iv) The child has difficulty playing games or sports within the rules.
(v) The child has difficulty communicating with others; e.g., in using verbal and nonverbal skills to express him/herself, carrying on a conversation, or in asking others for assistance.
(vi) The child has difficulty speaking intelligibly or with adequate fluency.

(j) *Moving about and manipulating objects.* In this domain, consider how the child moves his/her body from one place to another and how the child moves and manipulates things. These are called gross and fine motor skills.

(1) General.

(i) Moving the body involves several different kinds of actions: Rolling; rising or pulling from a sitting to a standing position; pushing up; raising one's head, legs, and twisting one's hands and feet; balancing one's weight on the legs and feet; shifting one's weight while sitting or standing; transferring oneself from one surface to another; lowering oneself to or toward the floor as when bending, kneeling, stooping, or crouching; moving oneself forward and backward in space as when crawling, walking, or running, and negotiating different terrains (e.g., curbs, steps, and hills).

(ii) Moving and manipulating things involves several different kinds of actions: Engaging one's upper and lower body to push, pull, lift, carry objects from one place to another; controlling shoulders, arms, and hands to hold or transfer objects; coordinating one's eyes and hands to manipulate small objects or parts of objects.

(iii) These objects require varying degrees of strength, coordination, dexterity, pace, and physical ability to persist at the task. They also require a sense of where one's body is and how it moves in space; the integration of sensory input with motor output; and the capacity to plan, remember and execute

controlled motor movements.

(2) Age group descriptors.

(i) Newborns and infants (birth to attainment of age 1). At birth, a child should begin to explore his/her world by moving his/her body and by using his/her limbs. The child should learn to hold his/her head up, sit, crawl, and stand, and sometimes hold onto a stable object and stand actively for brief periods. The child should begin to practice his/her developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers.

(ii) Older infants and toddlers (age 1 to attainment of age 3). At this age, the child should begin to explore actively a wide area of his/her physical environment, using his/her body with steadily increasing control and independence from others. The child should begin to walk and run without assistance, and climb with increasing skill. The child should frequently try to manipulate small objects and to use his/her hands to do or get something that he/she wants or needs. The child's improved motor skills should enable him/her to play with small blocks, scribble with crayons, and feed him/herself.

(iii) Preschool children (age 3 to attainment of age 6). As a preschooler, the child should be able to walk and run with ease. The child's gross motor skills should let him/her climb stairs and playground equipment with little supervision, and let him/her play more independently; e.g., the child should be able to swing by him/herself and may start learning to ride a tricycle. The child's fine motor skills should also be developing. The child should be able to complete puzzles easily, string beads, and build with an assortment of blocks. The child should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners.

(iv) School-age children (age 6 to attainment of age 12). As a school age child, the child's developing gross motor skills should let him/her move at an efficient pace about his/her school, home and neighborhood. The child's increasing strength and coordination should expand his/her ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching and hitting balls in informal play or at organized sports. The child's developing fine motor skills should enable him/her to do things like use many kitchen and household tools independently, use scissors, and write.

(v) Adolescents (age 12 to attainment of age 18). As an adolescent, the child should

be able to use his/her motor skills freely and easily to get about his/her school, the neighborhood, and the community. The child should be able to participate in a full range of individual and group physical fitness activities. The child should show mature skills in activities requiring eye-hand coordination, and should have the fine motor skills needed to write efficiently or type on a keyboard.

(3) Examples of limited functioning in moving about and manipulating objects. The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in the child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, all of the relevant information in the child's case record should be considered when deciding whether the child's medically determinable impairment(s) results in a "marked" or "extreme" limitation in this domain.

(i) The child experiences muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia) that interferes with his/her motor activities (e.g., the child unintentionally drops things).
(ii) The child has trouble climbing up and down stairs, or has jerky or disorganized locomotion or difficulty with his/her balance.
(iii) The child has difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, running, jumping rope, or riding a bike).
(iv) The child has difficulty with sequencing hand or finger movements.
(v) The child has difficulty with fine motor movement (e.g., gripping or grasping objects).
(vi) The child has poor eye-hand coordination when using a pencil or scissors.

(k) *Caring for oneself.* In this domain, consideration is given to how well the child maintains a healthy emotional and physical state, including how well the child gets his/her physical and emotional needs met in appropriate ways; how well the child copes with stress and changes in his/her environment; and whether he/she takes care of his/her own health, possessions, and living area.

(1) General.

(i) Caring for oneself effectively, which includes regulating oneself, depends upon the child's ability to respond to changes in his/her emotions and the daily

demands of his/her environment to help him/herself and cooperate with others in taking care of his/her personal needs, health and safety. It is characterized by a sense of independence and competence. The effort to become independent and competent should be observable throughout childhood.

(ii) Caring for oneself effectively means becoming increasingly independent in making and following one's own decisions. This entails that the child rely on his/her own abilities and skills, and display consistent judgement about the consequences of caring for him/herself. As the child matures, using and testing his/her own judgement helps him/her develop confidence in his/her independence and competence. Caring for oneself includes using one's independence and competence to meet one's physical needs, such as feeding, dressing, toileting, and bathing, appropriately for one's age.

(iii) Caring for oneself effectively requires the child to have a basic understanding of his/her body, including its normal functioning, and of his/her emotional needs. To meet these needs successfully, the child must employ effective coping strategies, appropriate for his/her age, to identify and regulate his/her feelings, thoughts, urges, and intentions. Such strategies are based on taking responsibility for getting one's needs met in an appropriate and satisfactory manner.

(iv) Caring for oneself means recognizing when one is ill, following the recommended treatment, taking medication as prescribed, following safety rules, responding to circumstances in safe and appropriate ways, making decisions that do not endanger oneself, and knowing when to ask for help from others.

(2) Age group descriptors.

(i) Newborns and infants (birth to attainment of age 1). The child's sense of independence and competence begins by being able to recognize his/her body's signals (e.g., hunger, pain, discomfort), to alert a caregiver to his/her needs (e.g., by crying), and to console him/herself (e.g., by sucking on his/her hand) until help comes. As the child matures, his/her capacity for self-consolation should expand to include rhythmic behaviors (e.g., rocking). The child's need for a sense of competence also emerges in things he/she tries to do for him/herself, perhaps before he/she is ready to do them, as when insisting on putting food in his/her own mouth and refusing a caregiver's help.

(ii) Older infants and toddlers (age 1 to attainment of age 3). As the child grows, the child should be trying to do more things for him/herself that increase his/her sense of independence and competence in his/her environment. The child might try to console him/herself by carrying a favorite blanket everywhere. The child should be learning to cooperate with his/her caregivers when they take care of the child's physical needs, but the child should also want to show what he/she can do; e.g., pointing to the bathroom, pulling off his/her coat. The child should be experimenting with his/her independence by showing some degree of contrariness (e.g., "No! No!") and identity (e.g., hoarding his/her toys).

(iii) Preschool children (age 3 to attainment of age 6). The child should want to take care of many of his/her physical needs by him/herself (e.g., putting on shoes, getting a snack), and also want to try doing some things that he/she cannot do fully (e.g., tying his/her shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for the child to do what a caregiver asks. Later, that may be difficult for the child because he/she wants to do things his/her way or not at all. These changes usually mean that the child is more confident about his/her ideas and what he/she is able to do. The child should also begin to understand how to control behaviors that are not good for him/her (e.g., crossing the street without an adult).

(iv) School-age children (age 6 to attainment of age 12). The child should be independent in most day-to-day activities (e.g., dressing him/herself, bathing him/herself), although he/she may still need to be reminded sometimes to do these routinely. The child should begin to recognize that he/she is competent in doing some activities and that he/she has difficulty with others. The child should be able to identify those circumstances when he/she feels good about him/herself and when he/she feels bad. The child should begin to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior. The child should begin to demonstrate consistent control over his/her behavior, and should be able to avoid behaviors that are unsafe or otherwise not good for him/her. The child should begin to imitate more of the behavior of adults he/she knows.

(v) Adolescents (age 12 to attainment of age 18). The child should feel more independent from others and should be increasingly independent in all of his/her day-to-day activities. The child may sometimes experience confusion in the way he/she feels about him/herself. The child should begin to notice significant changes in his/her body's development, and this could result in

anxiety or worrying about him/herself and his/her body. Sometimes these worries may make the child angry or frustrated. The child should begin to discover appropriate ways to express his/her feelings, both good and bad (e.g., keeping a diary to sort out angry feelings or listening to music to calm down). The child should begin to think seriously about his/her future plans, and what he/she will do when school is finished.

(3) Examples of limited functioning in caring for oneself. The following examples describe some limitations that may be considered in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in a child's case may depend on the child's age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, consider all of the relevant information in the child's case record when deciding whether the child's medically determinable impairment(s) result in a "marked" or "extreme" limitation in this domain.

(i) The child continues to place non-nutritive or inedible objects in his/her mouth. The child often uses self-soothing activities showing developmental regression (e.g., thumb- sucking, re-chewing food), or he/she has restrictive or stereotyped mannerisms (e.g., body rocking, head banging).
(ii) The child does not dress or bathe him/herself appropriately for his/her age because he/she has an impairment that affects this domain.
(iii) The child engages in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take his/her medication), or he/she ignores safety rules.
(iv) The child does not spontaneously pursue enjoyable activities or interests.
(v) The child has a disturbance in eating or sleeping patterns.

(l) *Health and physical well-being.* In this domain, consideration is given to the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on the child's functioning that were not considered in paragraph (j) of this section. When the child's physical impairment(s), mental impairment(s), or combination of physical and mental impairments has physical effects that cause "extreme" limitations in the child's functioning, the child will generally have an impairment(s) that "meets" or "medically equals" a listing.

(1) A physical or mental disorder may have physical effects that vary in kind and intensity, and make it difficult for the child to perform his/her activities

independently or effectively. The child may experience problems such as generalized weakness, dizziness, shortness of breath, reduced stamina, fatigue, psychomotor retardation, allergic reactions, recurrent infection, poor growth, bladder or bowel incontinence, or local or generalized pain.

(2) In addition, the medications that the child takes (e.g., for asthma or depression) or the treatments the child receives (e.g., chemotherapy or multiple surgeries) may have physical effects that also limit the child's performance of activities.

(3) The child's illness may be chronic with stable symptoms, or episodic with periods of worsening and improvement. Consider how the child functions during periods of worsening and how often and for how long these periods occur. The child may be medically fragile and need intensive medical care to maintain his/her level of health and physical well-being. In any case, as a result of the illness itself, the medications or treatment the child receives, or both, the child may experience physical effects that interfere with his/her functioning in any or all of his/her activities.

(4) Examples of limitations in health and physical well-being. The following examples describe some limitations we may consider in this domain. The child's limitations may be different from the ones listed here. Also, the examples do not necessarily describe a "marked" or "extreme" limitation. Whether an example applies in the child's case may depend on the child's age or developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, the child's limitations must result from his/her medically determinable impairment(s). However, consider all of the relevant information in the child's case record when deciding whether the child's medically determinable impairment(s) result in a "marked" or "extreme" limitation in this domain.

(i) The child has generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy, (e.g., fatigue or loss of energy or stamina), or psychomotor retardation because of his/her impairment(s).

(ii) The child has somatic complaints related to his/her impairment (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches, or insomnia).

(iii)The child has limitations in his/her physical functioning because of his/her treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary

cleansing, or nebulizer treatments).

(iv) The child has exacerbations from one impairment or a combination of impairments that interfere with his/her physical functioning.

(v) The child is medically fragile and needs intensive medical care to maintain his/her level of health and physical well-being.

(m) *Examples of impairments that functionally equal the listings.* The following are some examples of impairments and limitations that functionally equal the listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph, because these examples do not describe all possible effects of impairments that might be found to functionally equal the listings. As with any disabling impairment, the duration requirement must also be met.

(1) Documented need for major organ transplant (e.g., liver). Such cases of equivalence may be referenced to 106.02D (Renal Transplant) or 104.09 (Cardiac Transplantation), though there may be cases in which other listings would be more appropriate.

(2) Any condition that is disabling at the time of onset, requiring continuing surgical management within 12 months after onset as a life-saving measure or for salvage or restoration of function, and such major function is not restored or is not expected to be restored within 12 months after onset of this condition. Cases of equivalence may be referenced to the adult Listing 1.13, Soft Tissue Injuries of an Upper or Lower Extremity, though there may be cases in which other listings would be more appropriate.

(3) Frequent need for a life sustaining device (e.g., central venous alimentation catheter) at home or elsewhere. For some medical conditions, this may be equivalent to Listing 103.02C, Chronic Pulmonary Insufficiency.

(4) Effective ambulation possible only with obligatory bilateral upper limb assistance. For some medical conditions, this may be equivalent to Listing 101.03, Deficit of Musculoskeletal Function.

(5) Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms. For some medical conditions, this may be equivalent to the adult Listing 12.06C, Anxiety Related Disorders.

(6) Requirement for 24 hour a day supervision for medical (including psychological) reasons. For some medical conditions, this may be equivalent to listing 112.05B, Mental Retardation.

(7) Infants weighing less than 1200 grams at birth, until attainment of one year of age. Generally this is equivalent to Listing 100.02, Growth Impairment.

(8) Infants weighing at least 1200 but less than 2000 grams at birth, and who are small for gestational age, until attainment of one year of age. (Small for gestational age means a birth weight that is at or more than 2 standard deviations below the mean or that is below the third growth percentile for the gestational age of the infant.) Generally, this is equivalent to Listing 100.02, Growth Impairment.

(9) Major congenital organ dysfunction which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of one year of age. Cases of equivalence should be referenced to a listing for the appropriate body system; for example, Listing 104.06H, Congenital Heart Disease.

(10) Gastrostomy in a child who has not attained age three. Cases of equivalence may be referenced to Listing 103.02D, Tracheotomy, though there may be cases in which other listings would be more appropriate.

If the child's impairment <u>is</u> functionally equivalent in severity to a listed impairment, and it meets the duration requirement, the child will be determined disabled.

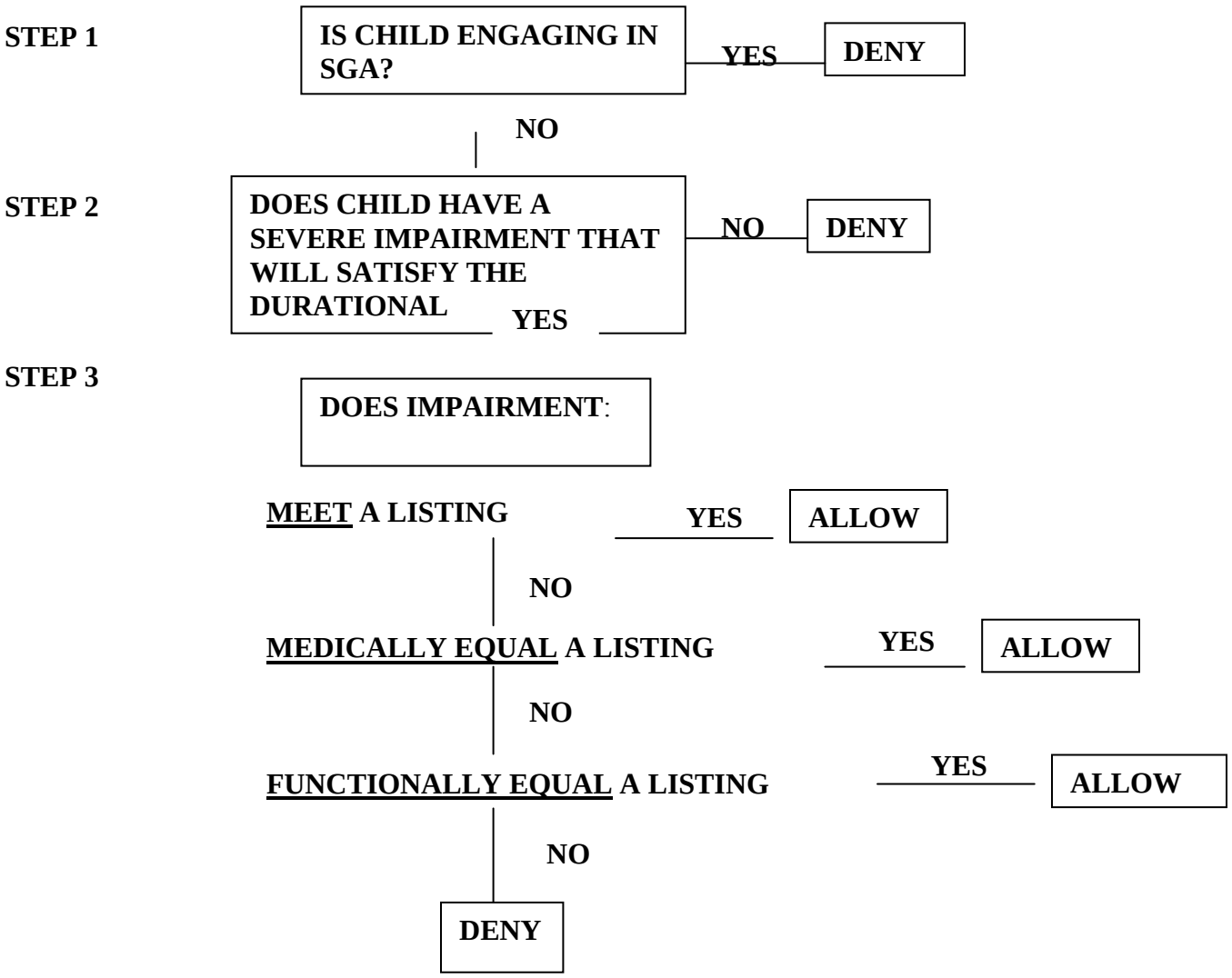
If the child's impairment <u>is not</u> functionally equivalent in severity to a listed impairment, or the duration requirement is not met, the child will be determined not disabled.

If the child has an impairment or combination of impairments that meets or equals a listing, and also meets the duration requirement, the child will be determined disabled.

<u>Note:</u> If the medical criteria in the children's listings do not apply, the adult medical listings should be used.

MEDICAID DISABILITY MANUAL

SEQUENTIAL EVALUATION FLOW CHART
CHILDREN



7. **Continuing Disability Review for Children**

a. General. As with adults, all children's disability cases classified as Group II require a continuing disability review prior to the expiration date to determine if the child continues to be disabled. It is important to note that substantial gainful activity is not considered in children's continuing disability review.

Continuing disability review determinations which are approved based on lack of medical improvement as described below should refer to 20 CFR 416.994a as a regulatory basis on the LDSS-639, "Disability Review Team Certificate".

Please note that much of the information pertaining to children's continuing disability review is the same as that for adults. Therefore, to avoid repetition, some of the information which is covered in the section on adult continuing disability review is referenced for sections in which this is appropriate.

b. Sequential Evaluation Process. The steps of the sequential evaluation process for children's continuing disability review cases are:

- Step 1 - Has there been medical improvement?
- Step 2 - Does the impairment still meet or equal the severity of the listed impairment that it met or equaled before?
- Step 3 - Is the child currently disabled?

NOTE: Steps in the sequence may be skipped if it is clear this would lead to a more prompt decision that disability continues. For example, the issue of medical improvement does not have to be considered if it is obvious from the evidence that the impairment meets the severity of a listed impairment.

1) **Medical Improvement - Has there been medical improvement in the child's condition**?

(a) Medical Improvement. Medical improvement is defined as any decrease in the medical severity of the child's impairment(s) which was present at the time of the most recent favorable decision that he/she was disabled or continued to be disabled. Although the decrease in severity may be of any quantity or degree, disregard minor changes in signs, symptoms, and laboratory findings that obviously do no represent medical improvement and could not result in a finding that disability has ended. A determination that there has been a decrease in

medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with the child's impairment(s).

(b) The most recent favorable decision. The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether the child was disabled or continued to be disabled.

(c) Temporary remissions. Some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. If the child has the kind of impairment that is subject to temporary remission, consider the longitudinal history including the occurrence of prior remissions and prospects for future worsening. Improvements that are only temporary do not warrant a finding of medical improvement.

(d) Evaluation. Has there been medical improvement in the child's condition(s)?

Determine whether there has been medical improvement in the impairment(s) since the time of the most recent favorable determination or decision. If there has been no medical improvement, disability continues, unless one of the exceptions to medical improvement applies. Refer to Policy 55.

If one of the first group of exceptions to medical improvement applies, proceed to Step 3. If one of the second group of exceptions to medical improvement applies, the disability may be found to have ended.

2) **Does the impairment(s) still meet or equal the severity of the listed impairment that it met or equaled before?** If there has been medical improvement, consider whether the impairment(s) that were considered at the time of the most recent favorable decision still meets or equals the severity of the listed impairment it met or equaled at that time. In making this decision, consider the current severity of the impairment(s) present and documented at the time of the most recent favorable determination or decision, and the same listing Section used to make that determination or decision as it was written at the time, even if it has since been revised or removed from the Listing of Impairments. If that impairment(s) does not still meet or equal the severity of that listed impairment, proceed to the next step. If that impairment(s) still meets or equals the severity of that listed impairment as it was written at the time find the child still disabled, unless one of the exceptions to medical improvement applies. If one of the first group of exceptions to medical improvement applies, proceed to Step 3. If one of the second group of exceptions to medical improvement applies, find that disability has ended.

3) **Is the child currently disabled?** If there has been medical improvement in the

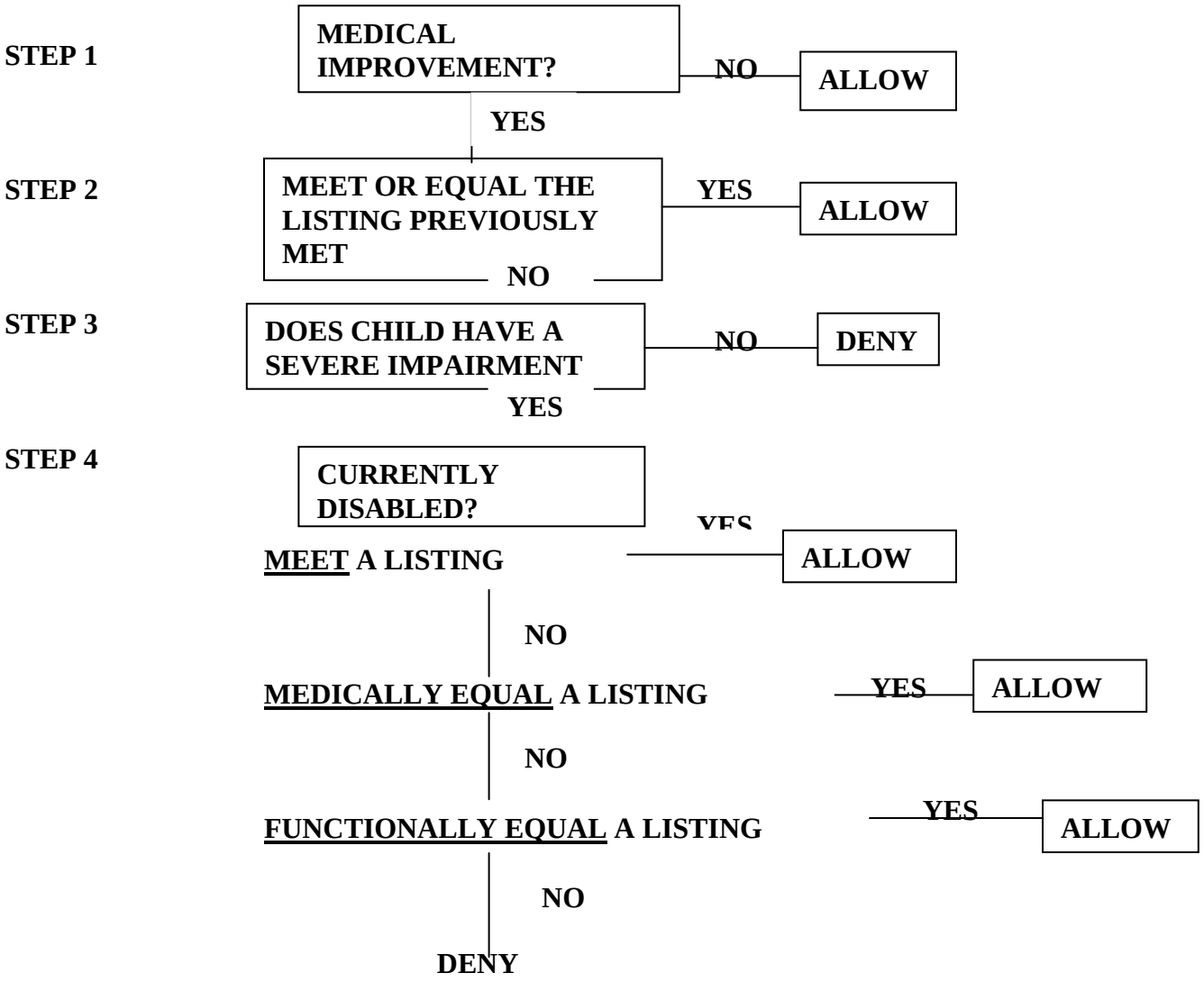
impairment(s) that were considered at the time of the most recent favorable determination or decision, and if that impairment(s) no longer meets or equals the severity of the listed impairment that it met or equaled at the time, consider whether the child is still disabled. In determining whether the child is currently disabled, consider all current impairments including those not present at the time of the most recent favorable decision, or that were not considered at that time. The steps in determining current disability are summarized as follows:

(i) Does the child have a severe impairment or combination of impairments? If there has been medical improvement in the impairment(s), or if one of the first group of exceptions applies, determine whether the current impairment(s) is severe. If the impairment(s) is not severe, find that disability has ended. If the impairment(s) is severe, consider next whether it meets or medically equals the severity of a listed impairment.

(ii) Does the impairment(s) meet or medically equal the severity of any impairment listed in Appendix 1? If the current impairment(s) meets or medically equals the severity of any listed impairment, find that disability continues. If not, consider whether it functionally equals the severity of a listed impairment.

(iii) Does the impairment(s) functionally equal the severity of any listed impairment? If the current impairment(s) functionally equals the severity of any listed impairment, find that disability continues. If not, find that disability has ended.

CONTINUING DISABILITY REVIEWS (CDR)
CHILDREN



Note: If the medical criteria in the children's listings do not apply, the adult medical listings should be used.

N. Zebley Children's Criteria

NOTE : The criteria in this section were effective prior to Public Law 104-193,which changed the definition of disability for children. The Balanced Budget Act of 1997 subsequently provided that the prior Zebley disability criteria are to be used for Medicaid purposes when evaluating children who were in receipt of SSI cash on August 22, 1996 and who lost SSI solely because of the change in the definition of disability. This section contains the previous Zebley criteria and is utilized only for children who lost SSI as specified in this paragraph.

1. General

For children from birth to the attainment of age 18, the sequential evaluation process used to evaluate disability is different from, though analogous to, that used for adults. This process, which is a result of the Supreme Court decision in Sullivan v. Zebley (91 ADM-35), differs from the adult process in that the bench mark criterion is the ability to function independently, appropriately, and effectively in an age-appropriate manner, rather than the ability to perform work that exists in the national economy (substantial gainful activity). This is reflected in the third step of "meets/equals", in which the concept of "functional equivalence" is introduced. It is also reflected in the fourth step, the "Individualized Functional Assessment" (IFA), which is analogous to the "medical-vocational" step of the adult sequential evaluation process.

A child is considered disabled if he/she has any medically determinable physical or mental impairment(s) "of comparable severity" to that which would disable an adult and meets the duration requirement.

The term "comparable severity" means that a child's physical or mental impairment(s) so limits the child's ability to function independently, appropriately, and effectively in an age-appropriate manner that the impairment(s) and its consequent limitations are comparable to those that would disable an adult. This means that a child's impairment(s) must substantially reduce or, in the case of infants from birth to age one, be expected to substantially reduce the ability to grow, develop, or mature in an age-appropriate manner.

Determinations based on an Individualized Functional Assessment should reference 20 CFR 416.924 as a regulatory basis on the DSS-639, "Disability Review Team Certificate".

2. Sequential Evaluation Process

As is the case for adults, the sequential evaluation process must be followed.

The steps of the sequential evaluation process for children's cases include:

- Step 1 - determining if the child is engaged in substantial gainful activity;
- Step 2 - determining if the child has a severe impairment(s);
- Step 3 - determining if the child's impairment(s) meets or equals a listing and meets the duration requirement; and,
- Step 4 - determining if the child's impairment(s) is of comparable severity to that which would disable an adult (IFA) and meets the duration requirement.

NOTE: If a child can be determined disabled at the "meets or equals" step, the last step in which an IFA is done (step 4), is not necessary.

a. Substantial Gainful Activity. Is the child engaging in substantial gainful activity?

   The basic statutory definition of disability requires an inability to engage in substantial gainful activity. The same rules for determining whether an adult is engaging in substantial gainful activity also apply to children. Except for some older children who may be employed, most children will not be engaged in substantial gainful activity, and it will be necessary to continue with the sequential process.

   If a child is engaging in substantial gainful activity, the child will be determined not disabled. If not, the sequential evaluation process will proceed to the next step.

b. Severity of Impairment. Does the child have a "severe" impairment or combination of impairments?

   If the child is found to have no more than a minimal limitation in the ability to function in an age-appropriate manner, the child will be determined not disabled. A determination of not disabled may be made at this step only if the child has no impairment or only a slight impairment(s) that does not significantly affect the child's ability to function independently, appropriately and effectively in an age-appropriate manner. If a child has an impairment or

combination of impairments that causes more than a minimal limitation in the ability to function, find that the child has a severe impairment(s) and go on to the next step in the process.

c. Meeting or Equaling the Listings. Does the child have a medically determinable impairment(s) that meets a listing? If so, the child will be determined disabled. If not, does the child have an impairment or combination of impairments that is medically or functionally equivalent in severity to any impairment in the Listing of Impairments? To determine a child disabled at the "meets or equals" step, the duration requirement must be met.

While all possible impairments or combinations of impairments are not described in the listings, the listings are a standard and a set of examples against which every impairment or set of impairments can be judged.

(1) **Medical Equivalence**

(a) With a listed impairment - Medical equivalence is established when the child has a listed impairment, but:

(i) not all the specified medical findings are present, or not all are as severe as specified; and

(ii) there are other medical findings related to the impairment that are at least of equal medical significance.

(b) With an unlisted impairment -Medical equivalence is established when the child has an unlisted impairment or combination of impairments, no one of which meets or is equivalent to a listing, but:

(i) the medical findings can be compared to a closely analogous listed impairment; and

(ii) the findings associated with the impairment(s) are at least of equal medical significance to those of the analogous listed impairment.

If the impairment(s) does not medically equal a listing, proceed to determine whether it functionally equals a listing.

(2) **Functional Equivalence.** If medical equivalence cannot be established as

above, the child must then be evaluated for functional equivalence. This means that the child"s functional limitation(s) which results from his or her impairment(s) must be compared with the functional consequences of any listed impairment which includes the same functional limitations. If the functional limitation(s) resulting from the impairment(s) is the same as the disabling functional consequences of a listed impairment, the child's impairment(s) will be found equivalent to the listed impairment. The child's impairment does not need to be medically related to the listing used for comparison. The primary focus is on the disabling consequences of the impairment, as long as there is a direct, medically determinable cause for these consequences. Functional equivalence is established when an impairment or combination of impairments causes the same disabling functional consequences as those caused by a listed impairment.

Examples of children's impairments that are functionally equivalent to the listings are listed below.

Please note that, for examples (c) - (i), there are medical reasons for the indicated impairments for which a different listing may be more analogous, and therefore more appropriate, than the referenced listing.

Cases of equivalence should be referenced to the specific equivalent listing.

Please also note that this is not an all inclusive list.

(a) Documented need for major organ transplant (e.g., heart, liver). Cases of equivalence should be referenced to a listing for the appropriate body system. For example, liver transplant would be equivalent to Listing 105.05, Chronic Liver Disease.

(b) Any condition that is disabling at the time of onset, requiring a series of staged surgical procedures within 12 months after onset as a life-saving measure or for salvage or restoration of major function, and such major function is not restored or is not expected to be restored within 12 months after onset of the condition. Cases of equivalence should be referenced to a listing for the appropriate body system. For example, a musculoskeletal impairment such as that described is equivalent to the adult Listing 1.13, Soft Tissue Injuries of an Upper or Lower Extremity.

(c) Daily need for a life-sustaining device (e.g., mechanical ventilation, central venous alimentation catheter, indwelling catheter for continuous ambulatory peritoneal dialysis), at home or elsewhere, lasting or expected to last 12 months. For some medical conditions, this may be equivalent to Listing 110.08A, Catastrophic Congenital Abnormalities or Disease.

(d) Complete inability to stand and walk. For some medical conditions, this maybe equivalent to Listing 111.06B, Motor Dysfunction (due to any neurological disorder).

(e) Marked inability to stand and walk, e.g., ambulation possible only with obligatory bilateral upper limb assistance. For some medical conditions, this may be equivalent to Listing 101.03B, Deficit of Musculoskeletal Function.

(f) Complete inability to perform self care skills. For some medical conditions, this may be equivalent to Listing 101.03C, Decificit of Musculoskeletal Function.

(g) Marked restriction of age-appropriate activities of daily living and marked difficulties in maintaining age-appropriate social functioning. For some medical conditions, this may be equivalent to Listing 112.02B, the paragraph B criteria for the Children's Mental Listings.

(h) Impairment causing complete inability to function independently outside the area of one's home within age-appropriate norms. For some medical conditions, this may be equivalent to the adult Listing 12.06C, Anxiety Related Disorders.

(i) Requirement for 24-hour a day supervision for medical or behavioral reasons, lasting or expected to last 12 months. For some medical conditions, this may be equivalent to Listing 103.03A, Bronchial Asthma.

(j) Premature infants (i.e., 37 weeks or less) weighing less than 1200 grams at birth (or within the first few days of life), until one year of age. Generally this is equivalent to Listing 100.02, Growth Impairment.

(k) Premature infants weighing at least 1200 but less than 2000 grams at birth (or within the first few days of life) and who are at least four weeks small for gestational age, until one year of age. Generally this is equivalent to Listing 100.02, Growth Impairment.

(l) In an infant who is not yet one year old, any physical disorder that satisfies the requirements of Listing 112.12. Generally this is equivalent to Listing 112.12, Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to Age One).

(m) Major congenital organ dysfunction (e.g., congenital heart disease) which

could be expected to result in death within the first year of life without surgical correction, until attainment of one year of age. Cases of equivalence should be referenced to a listing for the appropriate body system. For example, an impairment due to congenital heart disease such as that described is equivalent to Listing 104.02, Chronic Congestive Failure.

(n) Tracheostomy in a child who is not yet age three. Generally this is equivalent to Listing 103.03, Bronchial Asthma. Please note that, for a case in which a child had a tracheostomy for a brief period of time due to an acute illness, with subsequent closure, the duration requirement would not be met.

(o) Gross microcephaly of greater than three standard deviations. Generally this is equivalent to Listing 110.08, Catastrophic Congenital Abnormalities or Disease.

If the child has an impairment or combination of impairments that meets or equals a listing, and also meets the duration requirement, the child will be determined disabled. If not, proceed to the individualized functional assessment (IFA), which is the final step in the sequential evaluation process.

d. Individualized Functional Assessment (IFA). Does the child have an impairment or combination of impairments that so limits the child's physical or mental abilities to function independently, appropriately, and effectively in an age-appropriate manner that the resulting functional limitations are comparable in severity to those which would disable an adult?

(1) **General**. As the last step in the sequential evaluation process for children, an individualized functional assessment (IFA) must be done for the child, in order to determine whether or not comparable severity exists. An IFA considers the nature of the child's impairment(s), the child's age, and the child's ability to perform age-appropriate activities. This step is analogous to the medical-vocational assessment done for adults. All the evidence from medical and non-medical sources that can help in understanding how the child's impairment(s) affects his or her functioning must be considered. In addition, all other factors relevant to an assessment of the child's ability to perform age-appropriate activities are considered.

An IFA, then, considers four factors:

- The nature of the child's impairment(s) and impact on functioning;

- The child's age;
- Domains and Behaviors/Age-appropriate activities; and
- Other impairment related factors.

The discussion of the IFA begins with a discussion of the documentation needed to do an IFA. This is followed by a description of the above four factors, as they establish the parameters within which the IFA is made. The section which follows will discuss how these factors are considered in an IFA. These guidelines should not be applied mechanically or in a rigid manner. The examples given are not the only instances in which a child may be found to have comparable severity.

To determine a child disabled at the "individualized functional assessment" step, it is necessary that the duration requirement be met.

(2) **Documentation.** All information in the case record which documents the impact of the child's impairment on functioning will be considered. This information may be obtained from both medical and non-medical sources. A school psychologist who is licensed or certified for the independent general practice of psychology is considered an acceptable medical source. The report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is also acceptable medical evidence.

Non-medical sources include school records, parents and other family members, caregivers, teachers, and others who know the child and can provide evidence that can help in assessing the child's functioning on a longitudinal basis (i.e., over time).

Model forms have been developed to assist the agency in obtaining this information (see Forms and Publications 99-109). One form can be completed by the physician, a second by the child's caregiver, and a third by the child's school, if appropriate. All of these forms address the child's ability to function independently, appropriately, and effectively in an age-appropriate manner. While these forms are not required for the case record, they should be helpful in obtaining necessary evidence of the child's functioning.

When discrepancies in evidence exist, the differences should be reviewed and resolved. The case record should be documented to show how such discrepancies were resolved and the basis for any conclusions reached.

(3) **Age Categories**. When assessing whether the child is functioning independently, appropriately, and effectively in an age-appropriate manner, age will be considered in the following categories; however, these age categories must not be applied mechanically in borderline situations.

(a) **Newborn and young infants (birth to age one)**.

NOTE: See Policy 124 for guidelines for evaluating premature and low birthweight infants.

(b) **Older infants and toddlers (age one to age three).**

(c) **Children (age three to age 18).** Children are considered according to them following age subcategories:

- Preschool children (age three to age six);
- School-age children (age six to age 12);
- Young adolescents (age 12 to age 16); and
- Older adolescents (age 16 to age 18).

In general, the younger the child, the greater the impact of the child's impairment(s) on the ability to grow and develop. Although various kinds of growth and development occur throughout childhood and adolescence, the earliest years, from birth to approximately age six, are characterized by complex and rapid changes; for example, learning to walk, talk, and care for basic physical and emotional needs. The development of fundamental skills both within and across functional domains is a cumulative process founded upon skills acquired at each stage of a child's life. A child's ability to acquire or perform these skills ultimately determines the ability to master learning tasks in school and more complex physical activities and, eventually, affects the ability to work. Therefore, deficits of function resulting from impairments that occur before the age of six may have a potentially greater, more limiting effect on a child's overall growth and development than impairments that occur later in life. Such deficits are increasingly significant the younger the child is when the deficits occur.

Furthermore, the mastery of skills in early childhood is a highly interactive and interdependent process for a child. This interdependence is especially true of development in certain areas; e.g., cognitive skill deficits may affect communications, and social and emotional deficits may affect cognitive and communicative development. This interdependent process also requires

proper functioning in areas that may not be obviously relevant to the acquisition of the skill in question. For example, physical mobility is affected by how well a child sees; therefore, visual impairment, especially in a young child, can affect the way a child acquires certain motor skills even though the child does not have a specific motor impairment. Similarly, emotional bonding to parents can be affected by how well a child hears. Therefore, the impact of such seemingly isolated impairments can have implications for the overall development of the youngest children.

The younger the child, the greater the potential impact of physical or mental impairments is on the child's ability to function. This is analogous to the consideration of age in the adult medical-vocational rules when assessing the individual's ability to make an adjustment to other work. Whereas the older an adult is, the more significant the impact of a physical or mental impairment on the ability to adjust to other work, the reverse is generally true in a child. The younger the child, the more significant the impact of an impairment is likely to be. As a child approaches the age of 18, he or she is generally (though not always) comparable to a young adult (i.e., those age 18 to 45) in physical and mental makeup and potential.

This guidance must not be applied mechanically, since there are situations in which an impairment(s) acquired by an older child would have an equal or greater impact than the same impairment(s) would in a younger child. Each case must be evaluated on the basis of the child's individual circumstances, regardless of the child's age.

(4) **Domains and behaviors**.

(a) **General.** The terms "developmental domains" and "functional domains" refer to broad areas of development or functioning that can be identified in infancy and traced throughout a child's growth and maturation into adulthood. They describe the child's major spheres of activity:

(i) Cognitive: Refers to the ability to learn through perception, reasoning, or intuition, and to retain, use, and manifest acquired knowledge in action or communication.

(ii) Communicative: Refers to the ability to receive, comprehend, and express messages in order to meet one's needs or to obtain or convey information; with respect to speech, refers to audibility, intelligibility, and efficiency of speech production.

(iii) Motor: Refers to the ability to use one's body and extremities in gross and fine motions in order to relate to the physical environment and serve one's own physical needs or purposes.

(iv) Social: Refers to the ability to form, develop, and sustain relationships with other people on a personal and social basis, to respond appropriately within one's own social role or to the social roles of others, and to conduct oneself according to the manners and mores of one's social group.

(v) Personal/behavioral: Refers to activities and behaviors entailed in self-help (e.g., feeding, dressing, maintaining personal hygiene), self-regulation (e.g., maintaining proper nutrition, sleep, health habits, regulating mood), self- improvement (e.g., increasing self-help behavior through learning of new skills), self-protection (e.g., taking necessary safety precautions), and self-control (e.g., adapting to changes in environment or activity, controlling impulsive or aggressive behaviors that could otherwise result in harm to oneself, others, animals, or property).

The term "developmental domains" is generally used when discussing younger children, i.e., from birth to age six; the term "functional domains" is generally used when discussing older children and young adolescents, i.e., from age six to age 16.

The term "behaviors" refers to:

(i) Responsiveness to stimuli: Refers to physical and emotional behaviors in reaction to visual, auditory, or tactile stimulation, manifesting an infant's sensitivity to stimuli within a range of "normal", "hypersensitive" (excessive response, as in over-excitability or fearfulness), or "hyposensitive" (minimal or absent response, as in withdrawal or apathy).

(ii) Concentration, persistence, and pace: Refers to the ability to sustain focus on, and attention to, an activity or task, and to perform the activity or complete the task at a reasonable (or age-appropriate) rate.

(b) In an IFA, a child's functioning may be assessed in any or all of the following general and age-specific domains/behaviors:

(i) All Ages:

- o Cognition
- o Communication

- Motor Abilities
- Social Abilities

(ii) Birth to Age One:
- Responsiveness to Stimuli

(iii) Age One to Age 18:
- Personal/Behavioral Patterns

(iv) Age Three to Age 18:
- Concentration, Persistence, and Pace

Please refer to the chart on Policy 124 for specific descriptions of the domains/behaviors as applied to specific age groups. A complete discussion of older adolescents is found on Policy 133, as this age group is assessed in a manner more closely resembling the criteria for young adults.

DOMAINS/BEHAVIORS OF DEVELOPMENT AND FUNCTIONING FOR CHILDREN
Individualized Functional Assessment measures a child's behavior against the norms for age summarized below.

AGE	BIRTH-ONE	AGE ONE-THREE	AGE THREE-SIX	AGE SIX-12	AGE 12-16
COGNITION	Begins organizing and regulating feelings and responses to environment	Responds to increasingly complex requests, questions or instructions refers to self and things in environment by pointing and naming, imitating actions of others	Understands, reasons, solves problem; uses acquired knowledge and concepts	Learns skills involved and progress in reading, writing, mathematics	Applies skills and progresses in reading, writing, mathematics and conceptual growth, and in reasoning and problem solving
COMMUNICATION	Makes appropriate intentional visual, motor and vocal exchanges	Imitates, understands and uses an increasing number of intelligible words, eventually forms two or four word sentences	Tells, asks, predicts and relates information; follows/gives directions; expresses needs, feelings, preferences in an increasingly intelligible manner.	Communicates to meet needs and to exchange information and ideas with peers/family and at school	Communicates to meet needs and to exchange information and ideas with peers, family, or in school
MOTOR ABILITIES (gross and fine skills)	Explores environment by moving body; manipulates environment by using hands	Moves body independently with steadily increasing dexterity and independence; uses hands to do or get what's desired	Moves arms and legs and uses hands to manipulate small objects, with increasing coordination	Engages in age-appro-priate play, physical education and self-care	Engages in age-appropriate sports, physical education activities, social events and self-care
PERSONAL BEHAVIORIAL PATTERNS		Helps self or cooperates with others in meeting personal needs, learning new skills and adapting to environment	Helps self or cooperates with others in meeting needs, learning new skills and adapting to environment	Helps in caring for personal needs, safety; understands school rules, authority; develops responsibility for self; respect for others; learns new skills	Takes care of personal needs and safety; responds appropriately to school rules and authority; learns new skills
RESPONSIVENESS TO STIMULI	Responds appropriately to visual, auditory or tactile stimulation				
CONCENTRATION, PERSISTENCE AND PACE IN TASK COMPLETION			Engages in and sustains activities such as dressing, playing, etc. for a period of time and at pace appropriate to age	Engages in and sustains activities such as playing, reading, etc. for a period of time and at pace appropriate to age	Engages in and sustains activities such as studying, practicing sports, etc., for a period of time and at pace appropriate to age

(c) Other Terms Used to Describe Functioning. Other terms used to describe functioning are as follows:

(i) Age-appropriate activities. The term "age-appropriate activities" is a comprehensive term that refers to what a child is expected to be able to do given the child's age. A child's activities may be described in terms of the achievement of "developmental milestones", "activities of daily living" or other such terms.

Information about a child's activities creates a profile of how the child is functioning, i.e., what a child does, and thus what s/he is able to do. This makes possible a comparison between the child's profile and the activities that are age-appropriate for that child.

(ii) Developmental milestones. The term "developmental milestones" refers to a child's expected principal developmental achievements at particular points in time. Ordinarily, failures to achieve developmental milestones are the most important indicators of impaired functioning from birth until the attainment of age six, although they may be used to evaluate older children, especially school-age children.

(iii) Activities of daily living. The term activities of daily living" refers to those activities of children that involve continuity of purpose and action, and goal or task orientation; that is, the practical implementation of skills mastered at earlier ages. Ordinarily, activities of daily living are the most important indicators of functional limitations in children aged six to 18, although they may be used to evaluate younger children, especially preschool-age children.

(d) Description of domains and behaviors for older adolescents (age 16 to age 18). Descriptive information about the child's activities of daily living will indicate the nature and age-appropriateness of these activities with respect to cognitive functioning, communicative functioning, motor functioning, social functioning, personal/behavioral functioning and concentration, persistence and pace in school or work-related activities.

As the child approaches adulthood (i.e., beginning at about age 16), some school activities may be considered as evidence of the ability to function in a job setting. For example, the ability to understand, carry out, and remember short instructions and work-like procedures in the classroom; the ability to maintain attention for extended periods of time and to sustain an ordinary daily routine without special supervision; the ability to interact with authority

figures and to follow directions in school, responding appropriately to correction or criticism; the ability to regulate mood and behavior in various school settings; the ability to engage in physical activities both in and out of school; any skills which have been acquired from specific vocational education and whether any part-time or stay-in-school employment has been pursued.

If the child is working or has worked, the following must be evaluated: the physical activities in which the child is engaged on the job; the regularity and punctuality of attendance; the ability to follow directions and interact with supervisors; and the ability to work independently and to interact with others in the workplace.

(5) **Other Factors to be Considered in the Individualized Functional Assessment**.

When an individualized functional assessment is done, all factors that are relevant to the evaluation of the effects of the child's impairment(s) in regard to functioning will be considered, such as the effects of medications, the setting in which the child lives, the need for assistive devices, and how the child functions in school. Therefore, when assessing the effect of the child's impairment(s) on functioning, all evidence will be considered from both medical and non-medical sources. Some of the factors to be considered include but are not limited to the following:

(a) **Chronic illness**. If repeated hospitalizations or frequent outpatient care with supportive therapy is required for a chronic impairment(s), this need for treatment will be considered as a factor in the determination of the child's overall ability to function. If the child's hospitalizations are so long or so frequent that they interfere with overall functioning on a longitudinal basis, or if outpatient care significantly interferes with daily activities (either because of its frequency, its effects on functioning, or both), the child may be determined disabled because of the need for, or the level of, treatment for the child's chronic illness.

(b) **Effects of medication**. The effects of medication on the child's symptoms, signs, and laboratory findings will be considered, including any effects on the child's ability to function. Although medications may control the most obvious manifestations of the child's condition(s), they may or may not affect the functional limitations imposed by these impairment(s). If symptoms or signs are reduced by medications, any functional limitations which may nevertheless persist will be considered, even if there is apparent improvement from the medications. Any side

effects created by these medications which cause or contribute to the child's functional limitations will also be considered.

(c) **Effects of structured or highly supportive settings.** Children with severe impairments may spend much of their time in structured or highly supportive settings. A structured or highly supportive setting may be the child's own home, in which family members make extraordinary adjustments to accommodate the child's impairments; or the classroom at school, whether a regular class in which the child is accommodated, or a special classroom for children with similar needs; or a residential facility or school where the child lives for a period of time. Children with chronic impairments also commonly have their lives structured in such a way as to minimize stress, and reduce their symptoms or signs, and therefore some may be relatively free of obvious symptoms or signs of impairment. Others may continue to have persistent pain fatigue, decreased energy, or other symptoms or signs, though at a lesser level of severity. Such children may be more impaired in their overall ability to function in an age-appropriate manner than their symptoms and signs would indicate. Therefore, if symptoms or signs are controlled or reduced by the environment in which the child lives, the child's ability to function independently, appropriately, and effectively in an age-appropriate manner outside of this highly structured setting will be considered.

(d) **Adaptations**. The nature and extent of any other adaptations that are made for the child in order to enable the child to function will be considered. Such adaptations may include assistive devices, appliances, or technology. Some adaptive devices are relatively unobtrusive and may increase or restore functioning: examples of such devices may include eyeglasses, hearing aids, ankle-foot orthoses, and hand or foot splints. Others may be less effective or may impose additional limitations that interfere with performance of age-appropriate activities: examples of such devices may include specially adapted or custom-made tools, utensils, or support for self care activities such as bathing, feeding, toileting, dressing, and sleeping. When evaluating the child's overall ability to function independently, appropriately, and effectively in an age-appropriate manner with an adaptive device or other adaptation, such things as the degree to which the adaptation enables the child to function, and any additional limitations caused by the adaptation, will be considered.

(e) **Multidisciplinary therapy**. The child may need frequent and on-going

therapy from more than one kind of health care professional in order to maintain or improve function. This is considered to be multidisciplinary therapy, and may include occupational, physical or speech and language therapy, special nursing services, psychotherapy or psychosocial counseling. Frequent and continuous therapy, although intended to improve functioning, may also interfere significantly in the child's opportunities to engage in and sustain age-appropriate activities. If the child receives such therapy at school during a normal school day, it may or may not interfere significantly with age-appropriate activities. If the child must frequently interrupt activities at school or at home in order to go for therapy, these interruptions may interfere with development and age-appropriate functioning. When a determination is made as to whether a child has an impairment(s) of comparable severity to an impairment(s) that would disable an adult, the frequency of any multidisciplinary therapy that the child must have, how long the child has needed the therapy or will need the therapy, and the extent to which it interferes with age-appropriate functioning, will be considered.

(f) **School attendance**. School records and information from people at school who know or have examined the child such as teachers, school psychologists, psychiatrists, or therapists, may be important sources of information about the child's impairment(s) and its effect on ability to function. If the child attends school, this evidence will be considered.

The fact that the child is able to attend school will not in itself be an indication that he/she is not disabled. Consideration should be given to the circumstances of school attendance, such as the child's ability to function independently in a classroom setting in an age-appropriate manner. Likewise, the fact that he/she is in a special education classroom setting, or that he/she is not in such a setting will not in itself establish the child's actual limitations or abilities. Placement or lack of placement in such a setting will be considered in the context of the remainder of the evidence in the case record.

However, if the child is unable to attend school on a regular basis because of an impairment(s), this will be considered when determining whether or not the child is able to function in an age-appropriate manner.

(g) **Treatment and intervention, in general**. With adequate treatment or intervention, some children not only have their symptoms and signs reduced, but also return to or achieve a level of functioning that is consistent with the norms of their age. However, there are also cases in

which the child's actual level of impairment may be masked by the treatment or intervention. Therefore, the effects of the child's treatment or intervention will be evaluated to determine the actual outcome of the treatment or intervention in each particular case.

6) **Guidelines for Determining Disability using the Individualized Functional Assessment**.

(a) **General**. This section provides guidelines for using the IFA to decide whether or not a child who has a severe impairment that does not meet or equal the listings is nevertheless disabled. The examples in this section are only guidelines to illustrate severity and are not all-inclusive rules.

Forms have been developed to assist the reviewer in completing the individualized functional assessment. (See Forms and Publications 87-98). While these forms are not required for the case record, they should be helpful in making a determination based on an individualized functional assessment.

(b) **How functional limitations are described**. The terms used in this section to describe the functional severity of both physical and mental impairments are consistent with the terminology and definitions found in the childhood mental listings, Listing 112.00 of the Listing of Impairments. The examples of "moderate" and other impairments are derived from comparison with the "marked" levels of functional limitations in the listings. As in those listings, "marked" and "moderate" are not the number of activities or functions which are restricted, but the overall degree of restriction or combination of restrictions. A marked or moderate limitation may arise when several activities or functions are impaired, or even when only one is impaired.

A description of the terms "marked" and "moderate" is made within the context of describing their use for each of the different age categories. As the child gets older, these terms become less quantified, and in the discussion of older adolescents, an approach closely resembling the medical-vocational considerations as used in adult disability determinations is introduced.

(c) **Evaluating premature and low birth weight infants.** Chronological age (that is, a child's age based on birth date) is generally used when deciding whether, and the extent to which, a physical or mental impairment(s) affects a child's ability to function independently, appropriately, and effectively in an age-appropriate manner. However, if the child was born prematurely, he/she may be considered to be younger than the actual chronological age. An infant born at less than 37 weeks gestation is considered to be "premature-by-date".

Prematurity is considered as follows:

(i) Children born prematurely who satisfy the weight guidelines for establishing functional equivalence, (i.e., weight of less than 1200 grams at birth or within the first few days of life), will be found disabled at least until attainment of the chronological age of 12 months. The number of weeks of prematurity will not be a factor in the determination of disability.

(ii) Children born prematurely who satisfy the weight and size guidelines for establishing functional equivalence, (i.e., weight of at least 1200 grams but less than 2000 grams at birth or within the first few days of life, and at least four weeks "small for gestational age"), will be found disabled at least until attainment of the chronological age of 12 months. When deciding the extent to which a child was "small for gestational age" at birth, the child's actual gestational age, as shown by appropriate medical evidence, will be considered.

(iii) The cases of other children who were born prematurely will be evaluated in the same way that the cases of infants who were not premature are evaluated, applying the following principles:

When evaluating an impairment of development, a "corrected" chronological age will be used, that is, the chronological age adjusted by the period of gestational prematurity. The corrected chronological age is computed by subtracting the number of weeks of prematurity from the chronological age. This corrected age is used when evaluating developmental delay in premature children until it is no longer a significant factor - generally, at about age two.

When evaluating an impairment of linear growth, such as under the listing in 100.00, neonatal growth charts which have been developed to evaluate growth in premature-by-date infants are referenced. Because these growth charts already take prematurity into account, a corrected age is not computed in such cases.

(d) **Evaluating young children (birth to age three).** If the child is a newborn or young infant (birth to age one), the severity of the impairment(s) is evaluated with respect to four developmental domains (cognitive, communicative, motor, and social development and responsiveness to

stimuli).

If the child is an older infant or toddler (age one to age three), the severity of the impairment(s) is evaluated with respect to five developmental domains (cognitive, communicative, motor, social, and personal/behavioral development.)

For children in these age groups, the child's functional limitations will generally be described in terms of developmental delay, or the fraction or percentage of the child's chronological age that represents the level of the child's functioning. Failure to achieve development of no more than one-half of the child's chronological age in a single domain, or of no more than two-thirds of the child's chronological age in two domains represents listing level severity, and therefore represents functional/medical equivalence.

If the child is functioning in one of the domains or behaviors noted at more than one-half, but not more than two-thirds, of the child's chronological age, he/she is said to have a marked impairment. If the child is functioning in one of the domains or behaviors at more than two-thirds but not more than three-fourths of the child's chronological age, he/she is said to have a moderate impairment.

These guidelines, and those that follow, are not to be applied in a rigid or mechanical manner. Each case must be evaluated on the basis of the child's individual impairments.

Examples of when comparable severity will generally be found and thus, a determination of disabled made, include the following:

(i) The child is functioning at a marked level in one domain and functioning at a moderate level in another domain; or

(ii) The child is functioning at a moderate level in three domains.

(e) **Evaluating older children and young adolescents (age three to age 16)**. If the child is in this age group the severity of the impairment(s) is evaluated with respect to five functional domains (cognitive, communicative, motor, social, and personal/ behavioral function) and the child's concentration, persistence, and pace in the completion of age-appropriate tasks.

The terms "marked" and "moderate" are defined for this age group in a more

qualitative fashion than for younger children. "Marked" is defined as more than "moderate" but less than "extreme", and "moderate" means more than "mild" but less than "marked". An impairment may be considered "marked" when standardized tests are used as a measure of a child's functional ability and the child has a valid score that is two standard deviations below the norm (e.g., an IQ score of 70 on the WISC-R). An impairment may be considered "moderate" when the child has a valid score that is between approximately one and one-half and two standard deviations below the norm, (e.g., an IQ score on the WISC-R ranging from 71 through 77).

In the case of preschoolers (age three to age six), it may be appropriate to evaluate the level of severity in terms of developmental age, as in younger children. Although it is sometimes appropriate to evaluate severity in this age group in the same terms as those used for evaluating young children (e.g., describing "moderate" as more than two-thirds but not more than three-fourths of the child's chronological age), the older a child becomes, the less precise are the means of determining the level of severity.

Examples of when comparable severity will generally be found and, thus, a determination of disabled made, include the following:

(i) The child is functioning at the marked level in one domain (e.g., in the domain of social functioning, the child is generally unable to maintain age-appropriate relationships with peers and adults, with frequent serious conflicts with family, classmates, and teachers) and is functioning at the moderate level in another domain (e.g., in the domain of personal/ behavioral functioning he/she is frequently unable adequately to perform major age-appropriate activities of daily living); or

(ii) The child is functioning at the moderate level in three domains (e.g., in cognitive functioning, the child has a valid full scale IQ of 74; in social functioning, he/she has limited age-appropriate relationships with peers and adults, with occasional serious conflicts with family, classmates, teachers and others; and with respect to concentration, persistence and pace, the child is frequently unable to complete age-appropriate complex tasks, and occasionally unable to perform simple age-appropriate tasks adequately).

(f) **Evaluating older adolescents (age 16 to age 18)**. Children aged 16 to 18 are closely approaching adulthood and can be evaluated in terms that are the same as, or similar to, those used for the evaluation of the youngest adults. Children in this age range who do not have impairment-related limitations are

ordinarily expected to be able to do the kinds of physical and mental activities expected of individuals who are at least 18 years old.

The discussions in this section are based on the above principles. They describe limitations of physical and mental functions that are associated with, or related to, functions in the workplace, as demonstrated by a child's performance of age-appropriate activities in age-appropriate contexts, such as school, part-time or full-time work, vocational programs and organized activities. Information concerning the child's functioning in five functional domains (cognitive, communicative, motor, social, and personal/behavior) and in concentration, persistence, and pace, is also used to establish the child's ability, or potential ability, to perform physical and mental functions in the workplace.

As in the examples for younger children, the guidance for evaluating older adolescents is not intended to be all-inclusive or a standard by which all cases must be judged. Each case must be evaluated on the basis of the child's individual circumstances, using the principles and guidelines of the concepts and criteria presented in this section.

Consider the child's mental capacity to perform, on a sustained basis (i.e., eight hours a day, five days a week), the general kinds of mental activities that are evaluated for adults. This is done in order to determine if there is a substantial loss or deficit in the child's ability to meet any one of the basic mental demands of unskilled work. Consideration will be given to such things as the ability to understand, carry out, and remember simple instructions; to maintain attention for extended periods of time; to use judgement; to make simple decisions; to take necessary safety precautions; to respond appropriately to supervision and peers (e.g., by being able to accept instructions and criticism, by not requiring special supervision, and by not being unduly distracted by peers or unduly distracting to them in a school or work setting); and adapting to changes in the routine of the school or work setting.

Consider the child's physical capacity to perform, on a sustained basis (i.e., eight hours a day, five days a week), the types and ranges of exertional and nonexertional activities that are evaluated for adults. This includes activities such as sitting, standing, walking, lifting, carrying, pushing, pulling, reaching, handling, manipulating, seeing, hearing and speaking. These and any other relevant factors will be considered in order to determine if there is a substantial loss or deficit in the child's ability to meet any one of the basic physical demands of sedentary work.

If an individualized functional assessment shows that the child experiences a substantial loss or deficit of capacity to perform the age-appropriate mental or physical activities described, the impairment(s) will be found to seriously interfere with the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, and that it has substantially reduced the child's ability to acquire the skills needed to assume roles reasonably expected of adults.

Therefore, the child will be found to have an impairment(s) that is comparable in severity to an impairment that would disable an adult, and the child will be determined disabled.

3. **Continuing Disability Review**

a. General. As with adults, all children's disability cases classified as Group II require a continuing disability review prior to the expiration date to determine if the child continues to be disabled. It is important to note that substantial gainful activity is not considered in children's continuing disability review.

Continuing disability review determinations which are approved based on lack of medical improvement as described below should refer to 20 CFR 416.994a as a regulatory basis on the DSS-639, "Disability Review Team Certificate".

Please note that much of the information pertaining to children's continuing disability review is the same as that for adults. Therefore, to avoid repetition, some of the information which is covered in the section on adult continuing disability review is referenced for sections in which this is appropriate.

b. Sequential Evaluation Process. The steps of the sequential evaluation process for children's continuing disability review cases are:

- Step 1 - determining if the child meets or equals (medically or functionally) a listing;
- Step 2 - determining if there has been medical improvement;
- Step 3 - determining if medical improvement is related to the ability to work;
- Step 4 - determining if the child's impairment(s) is currently severe; and
- Step 5 - determining if the child's impairment(s) is comparable to that which would disable an adult.

(1) **Meeting or Equaling the Listings**. Does the child have an impairment or combination of impairments that meets or equals a listing?

If the child has an impairment that meets a current listing, or an impairment or combination of impairments that is of equivalent severity to a current listing, the child's disability will be found to continue. If not, the sequential evaluation process will continue to the next step.

(2) **Medical Improvement**

Has there been medical improvement in the child's condition?

(a) **Medical Improvement** - Medical improvement is defined as any decrease in the medical severity of the child's impairment(s) which was present at the time of the most recent favorable decision that he/she was disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with the child's impairment(s).

(b) **The most recent favorable decision** - The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether the child was disabled or continued to be disabled.

(c) **Temporary remissions** - Please refer to the appropriate section for discussion of how impairments which are subject to temporary remissions are evaluated.

(d) **Evaluation** - If there has been improvement in the child's symptoms, signs, or laboratory findings, medical improvement will be found to have occurred. A determination of medical improvement does not necessarily mean that the child's disability has ended. If it is determined that medical improvement has not occurred, a determination will then be made as to whether an exception applies. Please refer to Section G for definition/discussion of exceptions. Please note that the exception which pertains to an individual who is engaging in substantial gainful activity does not apply to children's cases. If a Group I exception applies, the sequential evaluation process will continue to the next step. If a Group II exception applies, a determination will be made that disability has ended. If no exception applies, the child will continue to

be found disabled. If medical improvement is found to have occurred, the sequential evaluation process will continue to the next step.

(e) Prior file cannot be located - If the prior file cannot be located, it will first be determined whether the child is currently disabled under the usual initial sequential evaluation process. In this way, the child's disability may be determined to continue without reconstructing prior evidence. If the child is determined disabled in this manner, the child's disability will continue unless one of the second group of exceptions applies. If not, follow the policies set forth in the CDR evaluation process keeping in mind that SGA is generally not a consideration in children's cases.

(3) **Medical Improvement as Related to the Ability to Work**. Is medical improvement related to the ability to work?

For a child, medical improvement is related to the ability to work when there has been an increase in the ability to function independently, appropriately, and effectively in an age-appropriate manner. Therefore, if the child's impairment(s) has medically improved as defined above, but the ability to function in an age-appropriate manner has not increased, the child's medical improvement will be found not related to the ability to work. A determination as to whether medical improvement is related to the ability to work will be made as follows:

(a) **Previous decision made on the basis of meeting/ equaling a listing** - If the most recent favorable decision was based on a finding that the child's impairment(s) met or equaled a listing that is in the current Listing of Impairments, and the impairment(s) no longer meets or equals that listing, then medical improvement has occurred, and is related to the ability to work.

If the most recent favorable decision was based on a finding that the child's impairment(s) met or equaled a listing that is no longer in the Listing of Impairments or that has since been revised, consider whether the child's impairment(s) continues to meet or equal that prior listing at this step. If the child's impairment continues to meet or equal the prior listing, the child's disability will be found to continue (provided that no exception applies), even though the impairment(s) does not meet or equal any current listing. If the impairment(s) no longer meets or equals the prior listing, there is medical improvement related to the ability to work.

(b) **Previous decision made on the basis of an individualized functional assessment** - If the most recent favorable decision was based on an

individualized functional assessment, a new individualized functional assessment will be done based on the previously existing impairment(s). However, the new individualized functional assessment will be based on those functions which are appropriate to the child's current age.

This assessment will be used to determine whether there has been an increase in the child's ability to function in an age-appropriate manner since the most recent favorable decision by comparing the current assessment with the assessment made at the time of the most recent favorable decision.

A new individualized functional assessment will not generally be done for the time of the most recent favorable decision. The assessment made at the time of the last decision will be used. However, if the assessment made at the time of the most recent favorable decision is not available (e.g., because it is missing from the child's file), the assessment will have to be reconstructed. This will be done by assuming that the child had the maximum functional abilities consistent with a decision of approval or continuance at the time of the most recent favorable decision.

If there has been improvement in the child's age-appropriate functioning, a determination will be made that the child's medical improvement is related to the ability to work.

If medical improvement is not related to ability to work, a decision must be made as to whether an exception applies. If no exception applies, the child will continue to be found disabled. If a Group I exception applies, the sequential evaluation process will continue to the next step. If a Group II exception applies, the child's disability will be found to have ended. If medical improvement is determined to be related to the ability to work, the sequential evaluation process will continue to the next step.

(4) **Severity of Impairment(s) -** A determination will be made as to whether the child has a severe impairment, as discussed in previous sections. If a severe impairment no longer exists, the child's disability will be found to have ended. If the child has a severe impairment(s), which has lasted, or is expected to last, at least 12 months or to result in death, the sequential evaluation process will continue to the next step.

(5) **Individualized Functional Assessment -** An individualized functional assessment will be done for the child. If the child is determined disabled on this basis, the child's disability will continue. If the child is found not to be disabled, disability will end.